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THE EMERGENCY MEDICAL SERVICES AND TRAUMA CARE IMPROVEMENT ACT OF 1989

MAY 15 (legislative day, APRIL 18), 1990.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 15]

The Committee on Labor and Human Resources, to which was referred the bill (S. 15) to amend the Public Health Service Act to improve emergency medical services and trauma care, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute, and recommends that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Emergency Medical Services and Trauma Care Improvement Act of 1990".

SEC. 2. FINDINGS.

The Congress finds that—

(1) the Federal Government and the governments of the States have established a history of cooperation in the development, implementation, and monitoring of integrated, comprehensive systems for the provision of emergency medical services throughout the United States;

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(2) physical trauma causes 140,000 deaths each year, is the leading cause of death of Americans between the ages of 1 and 44, and is the fourth leading cause of death in the general population of the United States;

(3) a disproportionate amount of serious trauma occurs in rural settings, the rural area death rate for motor vehicle accidents is over twice the rate for large cities, and 38 percent of all machinery-related deaths occur on farms even though farm workers constitute only four percent of U.S. workers;

(4) physical trauma in the United States results in an aggregate annual cost of $135,000,000,000 in medical expenses, insurance, administrative costs, property damage, and indirect costs (including more than an annual $31,000,000,000 in lost wages of individuals who are in their most productive work years);

(5) barriers still exist in many parts of the country that prevent quick and efficient emergency medical services from being provided;

(6) few States and communities have developed and implemented regional trauma care systems;

(7) uncompensated care costs associated with trauma have forced many trauma centers to drop out of trauma systems; and

(8) the number of deaths and disabilities resulting from incidents of physical trauma can be substantially reduced by improving emergency medical services systems and, in particular, the trauma care components of such systems.

SEC. 3. ESTABLISHMENT OF PROGRAMS WITH RESPECT TO TRAUMA CARE.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title XI the following new title:

"TITLE XII—TRAUMA CARE

"PART A—GENERAL AUTHORITY AND DUTIES OF SECRETARY

"SEC. 1201. CLEARINGHOUSE ON EMERGENCY MEDICAL SERVICES AND TRAUMA CARE.

"(a) ESTABLISHMENT.—The Secretary shall by contract provide for the establishment and operation of a National Clearinghouse on Emergency Medical Services and Trauma Care (hereinafter referred to in this title as the 'Clearinghouse').

"(b) DUTIES.—The Clearinghouse shall—

"(1) foster the development of appropriate, modern emergency medical services and trauma care (including the development of policies for the notification of family members of individuals involved in a medical emergency) through the sharing of information among agencies and individuals involved in planning, furnishing, and studying such services and care;

"(2) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing emergency medical services and trauma care and, in so doing, give special consideration of the unique needs of rural areas;

"(3) provide technical assistance relating to emergency medical services and trauma care to State and local agencies; and

"(4) sponsor workshops and conferences on emergency medical services and trauma care.

"(c) FEES AND ASSESSMENTS.—A contract entered into by the Secretary under this section may provide that the Clearinghouse shall charge fees or assessments in order to defray, and beginning with fiscal year 1991, to cover, the costs of operating the Clearinghouse.

"(d) AUTHORITY TO ENTER INTO CONTRACTS.—The authority of the Secretary to enter into contracts under this section shall be to such extent or in such amounts as are provided in Appropriation Acts.

"(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $500,000 for the later of fiscal year 1991 or the first fiscal year thereafter for which funds are appropriated under this section, $300,000 for the later of fiscal year 1992 or the second fiscal year after fiscal year 1991 for which funds are so appropriated, and $100,000 for fiscal year 1993 or the third fiscal year after fiscal year 1991 for which funds are so appropriated.

"SEC. 1202. GENERAL DUTIES.

"(a) IN GENERAL.—The Secretary shall—

"(1) conduct and support research, training, evaluations, and demonstration projects with respect to emergency medical services and trauma care systems;

"(2) provide to State and local agencies technical assistance relating to emergency medical services and trauma care systems; and

"(3) establish guidelines for the development of uniform State data reporting systems as described in section 1214(b)(8).

"(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

"PART B—GRANTS WITH RESPECT TO MODIFICATIONS OF STATE PLANS

"SEC. 1211. ESTABLISHMENT OF PROGRAM.

"(a) REQUIREMENT OF ALLOTMENTS FOR STATES.—

"(1) IN GENERAL.—Subject to section 1242(b), the Secretary shall for each fiscal year make an allotment for each State in an amount determined in accordance with section 1220.

"(2) APPLICATION.—The Secretary shall make payments each fiscal year to each State from the allotment for the State if the Secretary approves for the fiscal year involved an application submitted by the State pursuant to section 1219.

"(b) AVAILABILITY.—Any amount paid to a State for a fiscal year and remaining unobligated at the end of such year shall remain available for the next fiscal year to such State for the purposes for which such amount was paid.

"SEC. 1212. USE OF ALLOTMENTS.

"(a) PLANNING, IMPLEMENTING, ETC.—Not less than 35 percent of the total amount paid to a State under section 1211 for a fiscal year shall be used by a State to pay the costs of planning, implementing, monitoring, and evaluating the operation of, county, regional, or State trauma care systems. Such funds shall be administered by the head of the State agency or office responsible for the planning and coordination of emergency medical services system in the State. Each trauma care system supported with amounts made available under this subsection shall—

"(1) meet the standards and requirements established under the State plan submitted under section 1214;

"(2) provide for prehospital triage by paramedics, emergency medical technicians, and other emergency care providers to assess the severity of injury incurred by trauma patients;

"(3) provide for appropriate transportation and transfer policies, including those referenced in section 1214(c), to ensure the delivery of patients to designated trauma centers, including facilities with specialized capabilities and expertise in the care of pediatric trauma patients, and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers;

"(4) improve or establish injury prevention programs and conduct public education activities concerning obtaining access to emergency medical services and trauma care; and

"(5) establish criteria and procedures, in accordance with the State plan required under section 1214, for the identification and designation of trauma centers to participate in the trauma care system.

"(b) TRAUMA CARE EXPENDITURES.—Not less than 35 percent of the amount available for a fiscal year to a State from the total amount paid to the State under section 1211 for such fiscal year shall be used by the State to reimburse designated trauma centers for such portions of the uncompensated trauma care expenditures of such centers (including uncompensated professional services) as the State considers appropriate. In order to receive reimbursement for uncompensated trauma-care expenditures under this subsection, a designated trauma center shall—

"(1) be a center that—

"(A) meets the standards and requirements established by the State in accordance with the State plan required under section 1214; and

"(B) meets the guidelines for level I or level II trauma centers or in the case of rural communities, a level III trauma center as specified by the State plan required under section 1214;

"(2) serve an area in which the procedures and policies described in paragraphs (1) and (2) of subsection (a) have been implemented; and

"(3) maintain its designation as a designated trauma center throughout the fiscal year for which reimbursement is provided under this subsection.

"(c) REMAINING AMOUNTS.—After the application of subsections (a) and (b) for a fiscal year, the amount remaining available for such fiscal year to a State from the total amount paid to the State under section 1211 for such fiscal year may be used for any purposes for which funds are required to be used under such subsections.

"(d) ADJUSTMENTS IN USE OF AMOUNTS AND ADMINISTRATION.—

"(1) ADJUSTMENTS.—The percentage of the total amount paid to a State under section 1211 for a fiscal year that is required by subsection (a) to be used for the uses specified in such subsection may be adjusted by the Secretary in order to—

"(A) permit the State to use for such uses such greater proportion of such amount as the Secretary determines, based upon a demonstration by the State of the extent to which the State is unable to use 35 percent of such amount for reimbursements under subsection (b), that the State is unable to use for such reimbursements; or

"(B) permit the State to use for such uses such lesser proportion of such amount as the Secretary determines, based on a demonstration by the State of the extent to which the State does not need to use 35 percent of such amount for such uses in order to carry out adequately during such fiscal year the activities described in subsection (a), that the State needs to use for such uses.

"(e) ADMINISTRATIVE COSTS.—Not more than 5 percent of the total amount paid to a State under section 1211 for a fiscal year may be used for administering the funds made available under section 1211. The State shall pay from non-Federal sources the remaining costs of administering such funds.

"SEC. 1213. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FISCAL YEAR 1991.

"(a) IN GENERAL.—

"(1) PROHIBITION.—The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purposes described in section 1212, to make available non-Federal contributions (in cash or in kind under subsection (b)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in payments from the allotment for such fiscal year.

"(2) LIMITATION ON CONDITIONS.—With respect to an allotment under section 1211(a) for a State for fiscal year 1991, the Secretary may not require the State to make non-Federal contributions as a condition of receiving payments from the allotment.

"(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"SEC. 1214. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

"(a) STATE PLAN.—

"(1) TRAUMA CARE COMPONENT.—For each fiscal year, beginning with fiscal year 1991, each State shall submit the trauma care component of the State emergency medical services plan (hereafter in this section referred to as the 'State plan') to the Secretary.

"(2) INTERIM PLAN.—For fiscal year 1991, if a State has not completed the State plan, such State may provide, in lieu of a completed plan, an interim plan or description of efforts made toward the completion of the plan.

"(b) REQUIREMENTS OF PLAN.—Each State plan shall—

"(1) specify that the modifications required pursuant to paragraphs (2) through (10) will be implemented by the principal State agency with respect to emergency medical services or by the designee of such agency;

"(2) specify the State or local public agency or private entity that will designate trauma care regions and trauma centers in the State;

"(3) contain minimum standards and requirements for the designation of different categories of trauma centers (including facilities with specified capabilities and expertise in the care of the pediatric trauma patient) by such agency or entity, including standards and requirements for—

"(A) ensuring that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury which, in the case of level I or level II trauma centers, include the number and types of trauma patients for whom such centers must provide care in order to;

"(B) the resources and equipment needed by such centers;

"(C) the availability of rehabilitation services for trauma patients; and

"(D) the provision of assurances that such centers may not refuse the transfer of a trauma patient because the patient is unable to pay for the care that the patient requires;

"(4) contain standards and requirements for the implementation of regional trauma care systems, including standards and guidelines (consistent with the provisions of section 1867 of the Social Security Act (42 U.S.C. 1935d(d) and subsection (c) of this section) for medically directed triage and transportation of trauma patients;

"(5) contain standards and requirements for medically directed triage and transport of severely injured children to facilities with specified capabilities and expertise in the care of the pediatric trauma patient;

"(6) specify procedures for the evaluation of designated trauma centers (including facilities described in paragraph (5)) and trauma care systems;

"(7) provide that the standards and requirements described in paragraphs (3) and (4) address the special needs and problems of rural communities;

"(8) provide for the establishment in the State of a central data reporting and analysis system for—

"(A) identifying severely injured trauma patients within regional trauma care systems in the State;

"(B) identifying the nature and cause of severe injuries, and if known, factors contributing to the injury;

"(C) identifying patient outcomes;

"(D) monitoring trauma care resources (including prehospital care) within a regional trauma care system (including relevant rehabilitation information);

"(E) identifying the total amount of uncompensated trauma care expenditures made for each fiscal year by each trauma center in the State; and

"(F) identifying patients transferred within a regional trauma system, including reasons for such transfer;

"(9) provide periodic reviews of the transfers and the auditing of such transfers determined to be inappropriate;

"(10) improve or establish injury prevention programs and conduct public education activities concerning obtaining access to emergency medical services and trauma care; and

"(11) with respect to the requirements established in paragraphs (2) through (10), provide for the coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

"(c) EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS.—Appropriate transfer policies referred to in subsection (b)(4) and section 1212(a)(3) shall include the following requirements:

"(1) MEDICAL SCREENING REQUIREMENTS.—In the case of a hospital that has a hospital emergency department, if any individual comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital shall provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (as such term is defined in section 1867(e)(1) of the Social Security Act (42 U.S.C. 1395dd(e)(1))) exists or to determine if the individual is in active labor (as such term is defined in section 1867(e)(2) of the Social Security Act (42 U.S.C. 1395dd(e)(2))).

"(2) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—

"(A) IN GENERAL.—If any individual comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor (as so defined), the hospital must provide either—

"(i) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor; or

"(ii) for transfer of the individual to another medical facility in accordance with paragraph (3).

"(B) REFUSAL TO CONSENT TO TREATMENT.—A hospital shall be considered to meet the requirement of subparagraph (A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in such clause but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

"(C) REFUSAL TO CONSENT TO TRANSFER.—A hospital shall be considered to meet the requirements of subparagraph (A) with respect to an individual if

the hospital offers to transfer the individual to another medical facility in accordance with paragraph (3) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

"(3) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZES.—

"(A) GENERAL RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (as such term is defined in section 1867(e)(4)(B) of the Social Security Act (42 U.S.C. 1395dd(e)(4)(B))) or is in active labor, the hospital may not transfer the patient.

"(B) EXCEPTION.—A patient that has not been stabilized (as such term is defined in section 1867(e)(4)(B) of the Social Security Act (42 U.S.C. 1395dd(e)(4)(B))) or is in active labor may be transferred if—

"(i)(I) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

"(II) a physician, or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based on the reasonable risks and benefits to the patient, and based on the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

"(ii) the transfer is an appropriate transfer (within the meaning of subparagraph (D)) to that facility.

"(C) REQUIREMENT.—If a patient at a hospital has an emergency medical condition that has been stabilized, the hospital may transfer the patient but only by means of an appropriate transfer.

"(D) APPROPRIATE TRANSFER.—A transfer to a medical facility is an appropriate transfer if—

"(i) the receiving facility—

"(I) has available space and qualified personnel for the treatment of the patient, and

"(II) has agreed to accept transfer of the patient and to provide appropriate medical treatment, except that a hospital may not refuse to accept a transferred patient unless such hospital does not have the facilities or personnel available to provide proper care for such transferred patient, or the hospital has a full census at that time;

"(ii) the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment affected at the transferring hospital;

"(iii) the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

"(iv) the transfer meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the patient transferred.

"(4) CALL SCHEDULES.—In the case of a hospital that has a hospital emergency department, such hospital shall provide a call schedule that lists the appropriate medical specialists that will be immediately available for duty to provide ongoing, definitive treatment to a patient after the initial examination by the emergency physicians.

"(d) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.—

"(1) IN GENERAL.—In carrying out paragraphs (3), (4), and (5) of subsection (b), the State shall adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies. In adopting such standards the State shall—

"(A) take into account existing national standards concerning such;

"(B) consult with medical and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates and other interested parties;

"(C) conduct hearings on the proposed standards after providing adequate notice to the public concerning such hearing; and

"(D) beginning in fiscal year 1992, take into account the model plan described in subsection (e).

"(2) QUALITY OF TRAUMA CARE.—The highest quality of trauma care shall be the primary goal of State standards adopted under this subsection.

"(3) STATES WITH EXISTING STANDARDS.—In the case of a State that has adopted standards with respect to trauma care centers and systems prior to the date

of enactment of this title, such State shall demonstrate in the State plan that the State standards provide for the highest possible quality of trauma care and that the State—

"(A) took into account existing national standards in adopting such standards; and

"(B) consulted with medical and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates and other interested parties.

"(4) APPROVAL BY SECRETARY.—The Secretary shall not make payments under section 1211(a) for a fiscal year if the Secretary determines that—

"(A) the State has not taken into account existing national standards in adopting standards under this subsection;

"(B) beginning in fiscal year 1992, the State has not taken into account the model plan as described in subsection (e) in adopting such standards; and

"(C) the State has not developed such standards in an open process or has not provided all interested parties an opportunity to participate.

"(e) MODEL TRAUMA CARE PLAN.—Not later than 1 year after the date of enactment of this Act, the Secretary shall develop a model plan for the designation of trauma centers and for triage, transfer and transportation policies that may be adopted for guidance by the State. Such plan shall—

"(1) take into account existing national standards;

"(2) take into account existing State plans;

"(3) be developed in consultation with medical and nursing speciality groups, hospital associations, emergency medical services State directors and associations, concerned advocated and other interested parties; and

"(4) include standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to the nearest appropriate designated trauma center, and for triage, transfer, and transportation policies as they relate to rural areas.

Standards described in paragraph (4) shall be applicable to all rural areas in the State, including both non-metropolitan areas and frontier areas that have populations of less than 6,000 per square mile.

"SEC. 1215. REQUIREMENT OF ANNUAL REPORT BY DESIGNATED TRAUMA CENTERS.

"The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees to require each designated trauma center in the State to provide to the central data reporting system of the State pursuant to section 1214(b)(8) each fiscal year a report that—

"(1) specifies the number of severely-injured trauma patients cared for by such facility by injury severity grouping and nature of the injury during the fiscal year;

"(2) specifies the average length of hospital stay by such patients according to injury severity groupings during the fiscal year;

"(3) specifies the outcomes, including the disability outcome, of severely-injured trauma patients and their discharge disposition;

"(4) specifies the total amount of uncompensated trauma care expenditures incurred by such facility for such patients for such fiscal year; and

"(5) specifies the number of patients transferred in a manner not in accordance with the provisions of section 1214(c)(3)(D).

"SEC. 1216. REQUIREMENT OF PROVISION OF CERTAIN INFORMATION TO SECRETARY.

"(a) INFORMATION RECEIVED BY STATE REPORTING AND ANALYSIS SYSTEM.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that the State will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 1214(b)(8).

"(b) AVAILABILITY OF EMERGENCY MEDICAL SERVICES IN RURAL AREAS.—The Secretary may not make payments under section 1211(a) for a fiscal year unless—

"(1) the State involved identifies any rural area in the State for which—

"(A) there is no system of access to emergency medical services through the telephone number 911;

"(B) there is no basic life-support system; or

"(C) there is no advanced life-support system; and

"(2) the State submits to the Secretary a list of rural areas identified pursuant to paragraph (1) or, if there are no such areas, a statement that there are no such areas.

"SEC. 1217. RESTRICTIONS ON USE OF PAYMENTS.

"(a) IN GENERAL.—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

"(1) to make cash payments to intended recipients of services provided pursuant to such section;

"(2) to purchase or improve real property (other than minor remodeling of existing improvements to real property) or to purchase major medical or communication equipment, ambulances, or aircraft; or

"(3) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

"(b) EXCEPTION.—If the Secretary finds that the purpose described in section 1212 cannot otherwise be carried out, the Secretary may, with respect to an otherwise qualified State, waive the restriction established in subsection (a)(3).

"SEC. 1218. REQUIREMENT OF REPORTS BY STATES.

"(a) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees to prepare and submit to the Secretary an annual report in such form and containing such information as the Secretary determines (after consultation with the States and the Comptroller General of the United States) to be necessary for—

"(1) securing a record and a description of the purposes for which payments received by the State pursuant to such section were expended and of the recipients of such payments; and

"(2) determining whether the payments were expended in accordance with the purpose of the program involved.

"(b) AVAILABILITY TO PUBLIC OF REPORTS.—The Secretary may not make payments under section 1211(a) unless the State involved agrees that the State will make copies of the report described in subsection (a) available for public inspection.

"(c) EVALUATIONS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall, from time to time, evaluate the expenditures by States of payments under section 1211(a) in order to assure that expenditures are consistent with the provisions of the program involved.

"SEC. 1219. REQUIREMENT OF SUBMISSION OF APPLICATION CONTAINING CERTAIN AGREEMENTS AND ASSURANCES.

"The Secretary may not make payments under section 1211(a) to a State for a fiscal year unless—

"(1) the State submits to the Secretary an application for the payments containing agreements in accordance with section 1212 through section 1218;

"(2) the agreements are made through certification from the chief executive officer of the State;

"(3) with respect to such agreements, the application provides assurances of compliance satisfactory to the Secretary;

"(4) the application contains the information required to be submitted to the Secretary pursuant to sections 1214(a) and 1216(b)(2); and

"(5) the application otherwise is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

"SEC. 1220. AMOUNTS OF ALLOTMENTS.

"(a) FORMULA.—

"(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall allot to each State under section 1211(a) an amount that shall be the sum of the amounts allotted to the State under paragraphs (2) and (3).

"(2) POPULATION.—Eighty percent of the total amount made available under section 1242(b)(2) for a fiscal year shall be allotted to States under this paragraph. The allotment of a State under this paragraph shall be the amount that bears the same ratio to the amount available for allotment under this paragraph as the population of the State bears to the population of all States.

"(3) SQUARE MILEAGE.—Twenty percent of the total amount made available under section 1242(b)(2) for a fiscal year shall be allotted to States under this paragraph. The allotment of a State under this paragraph shall be the amount that bears the same ratio to the amount available for allotment under this paragraph as the square mileage of the State bears to the square mileage of all States.

"(4) MAXIMUM ALLOTMENT.—The total amount allotted to a State under this subsection shall not be greater than three times the greater of—

"(A) the amount the State would otherwise receive if a State's allotment were determined by the amount which bears the same ratio to the amount available for allotment as the population of the State bears to the population of all States; or

"(B) the minimum allotment as determined under subsection (b).

"(b) MINIMUM ALLOTMENT.—Notwithstanding subsection (a)—

"(1) if the total amount appropriated under section 1242 for any fiscal year equals or exceeds $25,000,000, the allotment of a State under this section for such fiscal year shall not be less than the greater of—

"(A) $250,000, or

"(B) an amount equal to one-half of one percent of the total amount appropriated to carry out this part for such fiscal year; or

"(2) if the total amount appropriated under section 1242 for any fiscal year is less than $25,000,000—

"(A) the Secretary shall allot 25 percent of such amount equally among the States; and

"(B) the Secretary shall allot 75 percent of such amount according to a formula developed by the Secretary designed to target funds to States that demonstrate in their applications the greatest commitment to establishing and maintaining trauma systems and that have the greatest need to develop, implement, and maintain such systems.

"(c) DISPOSITION OF CERTAIN FUNDS APPROPRIATED FOR ALLOTMENTS.—

"(1) IN GENERAL.—Amounts described in paragraph (2) shall, in accordance with paragraph (3), be allotted by the Secretary to States receiving payments under section 1211(a) for the fiscal year (other than any State referred to in paragraph (2)(C)).

"(2) TYPE OF AMOUNTS.—The amounts referred to in paragraph (1) are any amounts made available pursuant to 1242(b)(2) that are not paid under section 1211(a) to a State as a result of—

"(A) the failure of the State to submit an application under section 1219;

"(B) the failure, in the determination of the Secretary, of the State to prepare within a reasonable period of time such application in compliance with such section; or

"(C) the State informing the Secretary that the State does not intend to expend the full amount of the allotment made for the State.

"(3) AMOUNT.—The amount of an allotment under paragraph (1) for a State for a fiscal year shall be in proportion to the amount otherwise allotted to such State for the fiscal year without regard to this subsection.

"SEC. 1221. FAILURE TO COMPLY WITH AGREEMENTS.

"(a) REPAYMENT OF PAYMENTS.—

"(1) IN GENERAL.—The Secretary may, in accordance with subsection (b), require a State to repay any payments received by the State pursuant to section 1211(a) that the Secretary determines were not expended by the State in accordance with the agreements required to be made by the State as a condition of the receipt of payments under such section.

"(2) FAILURE TO REPAY.—If a State fails to make a repayment required in paragraph (1), the Secretary may offset the amount of the repayment against any amount due to be paid to the State under section 1211(a).

"(b) OPPORTUNITY FOR A HEARING.—Before requiring repayment of payments under subsection (a)(1), the Secretary shall provide to the State an opportunity for a hearing.

"SEC. 1222. PROHIBITION AGAINST CERTAIN FALSE STATEMENTS.

"(a) IN GENERAL.—

"(1) MATERIAL FACT.—A person may not knowingly make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made by a State from amounts paid to the State under section 1211(a).

"(2) INTENT TO DEFRAUD.—A person with knowledge of the occurrence of any event affecting the right of the person to receive any payments from amounts paid to the State under section 1211(a) may not conceal or fail to disclose any such event with the intent of fraudulently securing such amount.

"(b) CRIMINAL PENALTY FOR VIOLATION OF PROHIBITION.—Any person who violates a prohibition established in subsection (a) may for each violation be fined in accordance with title 18, United States Code, or imprisoned for not more than 5 years, or both.

"SEC. 1223. TECHNICAL ASSISTANCE AND PROVISION BY SECRETARY OF SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.

"(a) TECHNICAL ASSISTANCE.—The Secretary shall, without charge to a State receiving payments under section 1211(a), provide to the State (or to any public or nonprofit private entity designated by the State) technical assistance with respect to the planning, development, and operation of any program or service carried out pursuant to section 1212. The Secretary may provide such technical assistance directly, through contract, or through grants.

"(b) SUPPLIES AND SERVICES.—

"(1) IN GENERAL.—On the request of a State receiving an allotment under section 1211(a), the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out section 1211(b) and, for such purpose, may detail to the grantee any officer or employee of the Department of Health and Human Services.

"(2) REDUCTION IN AMOUNTS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments to the State under section 1211(a) by an amount equal to the fair market value of any supplies, equipment, or services provided by the Secretary and shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

"SEC. 1224. REPORT BY SECRETARY.

"Not later than February 1, 1993, the Secretary shall prepare and submit to the appropriate Committees of Congress a report on the activities of the States carried out pursuant to section 1211. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives and shall include—

"(1) an evaluation of the trauma system plans and standards of the State and their respective data as required by section 1216(a);

"(2) recommendations regarding the plans and standards that result in the most favorable patent outcomes; and

"(3) recommendations regarding and, if appropriate, modifications of the model State plan as required by section 1214(e).

"PART C—RURAL EMERGENCY MEDICAL SERVICES AND TRAUMA CARE

"SEC. 1231. IMPROVING RURAL EMERGENCY MEDICAL SERVICES AND TRAUMA CARE.

"(a) GRANT PROGRAM.—

"(1) IN GENERAL.—The Secretary shall make grants, on a competitive basis, to States to carry out activities to improve rural emergency medical services.

"(2) APPLICATION.—A State wishing to receive a grant under this section shall prepare and submit an application at such time, in such form, and containing such information, including the proposed activities and projects to be assisted with such grants, to the Secretary.

"(3) REDISTRIBUTION.—Grants made to States under this section shall be redistributed to the individuals, organizations, or governmental entities on whose behalf the State submitted an application under this section.

"(b) PRIORITY.—In making grants under this section, the Secretary shall give priority to—

"(1) projects aimed at filling gaps in basic and advanced life support emergency medical services in rural communities;

"(2) projects that are necessary in order for the State to carry out the activities described under section 1212; and

"(3) States and communities that serve large numbers of individuals that reside in rural communities;

"(c) ACTIVITIES AND PROJECTS.—Financial assistance may be provided with a grant received under subsection (a) by a State for—

"(1) the support of rural emergency medical services systems;

"(2) the recruitment, training, and retention of personnel to provide emergency medical services and system support, including first responders, emergency medical technicians, paramedics, and emergency medical services systems managers;

"(3) the purchase, upgrading, and maintenance of medical and communications equipment relating to emergency medical services, including equipment for the implementation 911 telephone systems;

"(4) the improvement and maintenance of transportation services for medical emergencies; and

"(5) the conduct of public education activities concerning preventing injuries of special concern to rural communities, including injuries to children resulting from farm equipment, and obtaining access to emergency medical services and trauma care.

"PART D—GENERAL PROVISIONS

"SEC. 1241. DEFINITIONS.

"As used in this title—

"(1) DESIGNATED TRAUMA CENTER.—The term 'designated trauma center' means a trauma center designated in accordance with the modifications to the State plan described in section 1214.

"(2) PLAN FOR THE PROVISION OF EMERGENCY MEDICAL SERVICES.—The term 'plan for the provision of emergency medical services' means a plan for a comprehensive, organized system to provide for the access, response, triage, field stabilization, transport, hospital stabilization, definitive care, and rehabilitation of patients of all ages with respect to emergency medical services.

"(3) STATE.—The term 'State' means each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

"(4) TRAUMA CARE COMPONENT OF THE PLAN FOR THE PROVISION OF EMERGENCY MEDICAL SERVICES.—The term 'trauma care component of the plan for the provision of emergency medical services' means a plan for a comprehensive health care system, within rural and urban areas of the State, for the prompt recognition, prehospital care, emergency medical care, acute surgical and medical care, rehabilitation, and outcome evaluation of seriously injured patients.

"(5) UNCOMPENSATED TRAUMA CARE EXPENDITURES.—The term 'uncompensated trauma care expenditures' means any amount that is expended by a health care facility to provide health care services to a trauma patient and for which such facility does not receive payment or reimbursement.

"SEC. 1242. FUNDING.

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there is authorized to be appropriated $75,000,000 for each of the fiscal years 1991 through 1993.

"(b) ALLOCATION OF FUNDS BY SECRETARY.—

"(1) PART A.—For the purpose of carrying out part A, the Secretary shall make available 5 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).

"(2) PART B.—For the purpose of making allotments under section 1211(a), the Secretary shall make available 80 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).

"(3) PART C.—For the purpose of making grants under section 1231(a), the Secretary shall make available 15 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).".

SEC. 4. REQUIREMENT OF CERTAIN STUDIES RELATING TO TRAUMA CARE.

(a) MEDICAID POLICIES OF STATES.—The Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall conduct a study for the purpose of determining the policies adopted by States in reimbursing trauma centers pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The study shall assess the adequacy and appropriateness of the reimbursements provided pursuant to such title by States to such centers and shall include recommendations with respect to whether the requirements imposed under such title should be modified in order to ensure that such centers are appropriately reimbursed.

(b) LONG-TERM ECONOMIC EFFECTS OF TRAUMA.—The Secretary shall conduct a comprehensive multidisciplinary study of the long-term economic effects of incidences of trauma in the United States. In conducting the study, the Secretary shall utilize the services of individuals with expertise in appropriate fields (including epidemiology, statistics, behavioral sciences, and health economics) in order to identify and evaluate as many factors as possible that influence the impact and long-term outcome of a trauma incident.

(c) TIME FOR COMPLETION.—The Secretary shall, not later than 1 year and 3 years after the date of enactment of this Act, complete the studies required in subsections (a) and (b), respectively, and submit to the appropriate Committees of Congress a report describing the findings made as a result of the studies.

SEC. 5. COOPERATION BETWEEN STATE AGENCIES.

(a) CERTIFICATIONS REQUIRED IN APPLICATIONS FOR PHHS BLOCK GRANT.—Section 1905(c) of the Public Health Service Act (42 U.S.C. 300w-4(c)) is amended—

(1) by striking out "and" at the end of paragraph (5);

(2) by striking out the period at the end of paragraph (6) and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new paragraph:

"(7) agrees to provide the officer of the State government responsible for the administration of the State highway safety program with an opportunity to—

"(A) participate in the development of any plan by the State relating to emergency medical services, as such plan relates to highway safety, including the State plan required by section 1910B; and

"(B) review and comment on any proposal by any State agency to use any Federal grant or Federal payment received by the State for the provision of emergency medical services as such proposal relates to highway safety.".

(b) HIGHWAY SAFETY PROGRAM.—Paragraph (1) of section 402(b) of title 23, United States Code, is amended—

(1) by striking out the period at the end of each subparagraph and inserting in lieu thereof a comma;

(2) by adding "or" at the end of subparagraph (F); and

(3) by adding at the end thereof the following new subparagraph:

"(G) provide procedures that ensure that State officials who are responsible for the administration, planning, and coordination of emergency medical services within the State have the opportunity to—

"(i) participate in the development of the State highway safety program as such program relates to emergency medical services;

"(ii) provide advice on the development and implementation of those provisions of the State highway safety program related to emergency medical services; and

"(iii) review, and comment on, any proposals to use funds provided to the State under this section for emergency medical services.".

SEC. 6. IMPROVING COMMUNICATIONS SYSTEMS.

(a) WATER AND WASTE FACILITY LOANS AND GRANTS.—The first sentence of section 306(a)(1) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1926(a)(1)) is amended by inserting "emergency telephone service, communications equipment for emergency medical services," after "recreational developments,".

(b) FEDERAL COMMUNICATIONS COMMISSION.—Not later than 1 year after the date of enactment of this Act, the Federal Communications Commission shall—

(1) complete a study of the availability of radio frequency channels for emergency medical services communications (including in such study, to the maximum feasible extent, an analysis of communications between public and private ambulances and public and private hospitals);

(2) establish a plan to ensure that the needs of emergency medical services communications (including effective prehospital communications) shall be adequately provided for in the allocation of frequencies for public safety; and

(3) prepare and submit, to the appropriate Committees of Congress, a report that contains the results of such study and plan relating to emergency medical services communications.

SEC. 7. EFFECTIVE DATE.

This Act and the amendments made by this Act shall take effect October 1, 1990, or on the date of the enactment of this Act, whichever occurs later.

I. SUMMARY

As reported by the committee, S. 15 establishes a new title XII under the Public Health Service Act which provides for the establishment and operation of a National Clearinghouse on Emergency Medical Services, the authorization of a Trauma Care Block Grant, which includes a set aside for rural emergency medical services, and other activities related to the development of coordinated regionalized emergency medical services and trauma care systems in the United States.

The bill authorizes the Secretary of Health and Human Services (HHS) to provide by contract for the establishment and operation of a National Clearinghouse on Emergency Medical Services under title XII of the Public Health Service Act (PHS). The Clearinghouse will: (1) foster the development of emergency medical services and trauma care through the sharing of information; (2) collect, compile, and disseminate information, giving special consideration to the unique needs of rural areas; (3) provide technical assistance; and (4) sponsor workshops and conferences.

The bill authorizes a new Trauma Care Block Grant under title XII of the PHS Act. Appropriations under this block grant will be allotted to the States on the basis of the population (80 percent), the square mileage (20 percent), of each State, with no State receiving less than $250,000 or one-half of 1 percent of the amount appropriated. States will be required to provide $1 in cash or in kind for each $3 of federal funds.

States will have to use at least 35 percent of their allotments under the trauma care block grant to pay the costs of planning, implementing, monitoring, and evaluating the operation of county, regional, or State trauma care systems. Each such trauma system will have to meet standards and requirements established under a State plan mandated under the bill. Each system will provide for the use of triage procedures to assess the severity of injury incurred by trauma patients and will establish appropriate transportation and transfer policies, including medical screening requirements, necessary stabilizing treatment for patients with emergency medical conditions and patients in active labor, restricting transfers until patient stabilizes, and call schedules. A trauma system under this block grant will have to establish a public education program on injury prevention and access to emergency medical services and trauma care. Finally, a trauma system will have to establish criteria and procedures for the identification and designation of trauma centers to participate in the trauma care system.

At least 35 percent of a State's allotment under the trauma care block grant will have to be used by the State to reimburse designated trauma centers for uncompensated trauma care provided by such centers. States may use the remaining amounts for either planning and implementation of trauma systems or for reimbursement.

S. 15 as reported requires each State to submit to the Secretary a State plan for trauma care. Each plan will have to provide for planning, development, and implementation of regional trauma care systems within a regional emergency medical services system. Each plan must contain minimum standards requirements for the designation of trauma centers and for triage and transportation policies, including standards and requirements for the triage and transport of severely injured children. The plan will have to specify procedures for the evaluation of trauma facilities and specialized facilities for pediatric trauma care and for the periodic reviews of transfers. The plan must provide for the establishment of a central reporting and analysis system. Finally, the plan will provide for the establishment of an injury prevention program, and provide assurances of coordination and cooperation between the State and any other State which shares a metropolitan area.

In developing trauma system standards and requirements, states are required to take into account existing national standards, consult with medical and other specialists and conduct hearings on the proposed standards. The Secretary is required to develop a model plan for the designation of trauma centers and for triage, transfer and transportation policies that may be adopted for guidance by states.

States must provide the Secretary information collected in their central reporting systems and information concerning rural areas in which certain emergency medical services do not exist.

S. 15 as reported requires the Secretary to set aside 15 percent of the funding for rural EMS project grants. Priority shall be given to projects aimed at filling gaps in basic and advanced life support emergency medical services, projects that are necessary in order for the state to implement a trauma system, and states and communities that serve large rural communities.

S. 15 as reported requires the Secretary to prepare and submit to the appropriate Congressional Committee a report describing an evaluation of trauma system plans and standards and their respective data and the activities of the States under the trauma care block grant, including recommendations for appropriate administrative and legislative initiatives.

The Secretary will be required to conduct a comprehensive study on the long-term economic effects of incidents of trauma in the U.S. and a study regarding the adequacy and appropriateness of reimbursements for trauma under Medicaid, to be submitted to the appropriate Congressionial Committees not later than 1 year after the date of enactment of the bill.

S. 15, as reported requires the state health and transportation agencies cooperate in the development of plans relating to emergency medical services and highway safety.

II. Background and Need for Legislation

The Emergency Medical Services and Trauma Care Improvement Act has two primary goals. First, it is designed to remove the barriers and rectify the problems that, in many parts of the country, prevent quick and efficient emergency medical services (EMS) from being provided. Second, it would provide incentives for States and localities to establish well-coordinated regionalized trauma-care systems that would enable severely injured individuals to receive highly specialized trauma care as rapidly as possible following their injury.

THE COSTS OF INJURY

In 1985, the prestigious National Academy of Sciences issued a report, "Injury in America", which asesssed the magnitude and characteristics of injury in the United States, efforts to prevent and treat injury, and Federal support for injury research. It was conducted as a follow-up to a landmark study conducted 20 years earlier by the National Research Council, entitled "Accidental Death and Disability: The Neglected Disease of Modern Society." The National Academy of Sciences concluded that, tragically, insuf-

ficient progress had been made in injury control since the first study was reported.

Each year, approximately 145,000 Americans die from injuries and 2.3 million Americans suffered injuries serious enough to warrant hospitalization. Injury is the fourth leading cause of death among all Americans and the major killer of children and young adults. More Americans between the ages of 5 and 34 die from injuries than from all diseases combined.

Injury is also a leading cause of short- and long-term disability. More than 80,000 persons become permanently disabled from brain or spinal cord injuries each year. Over 4 million years of future worklife are lost to injury annually—nearly double that lost to heart disease or cancer.

Injury represents one of our most expensive health problems. According to a 1989 report to Congress, entitled "Cost of Injury in the United States", injury "imposed a $158 billion burden on the U.S. economy" in 1985. The total economic cost is estimated to have risen to $180 billion in 1988. Seventy-five percent of the costs are incurred in the first year of injury with the remaining twenty-five percent incurred in later years.

The report further concluded that, of the total lifetime costs, direct costs for medical care and rehabilitation account for $45 billion or 29 percent; morbidity costs—the value of goods and services not produced because of injury-related illness and disability—account for $64.9 billion or 41 percent; and mortality costs—the value of lifetime earnings lost from individuals who die prematurely from injury—account for $47.9 billion or 30 percent.

The federal government's share of the cost of injuries is enormous. Of all direct medical care costs, the federal government pays $8.9 billion or 21 percent. The federal government also pays $13 billion in disability and death benefits under Social Security Disability Insurance, Supplemental Security Income, the Department of Veterans' Affairs, and Workers' Compensation.

Much of the death and disability resulting from injury—particularly severe injury—can be prevented or ameliorated by quick-response teams providing prehospital care and through the accessibility and availability of sophisticated emergency hospital care when needed. In Washington, D.C. trauma deaths declined 50 percent over a five year period after implementation of a trauma system and fell 55 percent in San Diego. Experts estimate that as many as 25,000 trauma deaths per year in the United States could be prevented with appropriate medical treatment. At least two studies show that with prompt, expert trauma care over 80 percent of the most seriously injured patients return to full-time productivity four years following the injury, with most regaining full activity within one year.

Well-coordinated EMS and trauma care systems help ensure that injury and trauma victims—as well as others, such as heart attack victims, in need of emergency care—receive that kind of swift and effective medical attention. Regional trauma systems are also cost effective by providing for appropriate distribution and utilization of expensive health-care technology and resources.

RURAL EMERGENCY MEDICAL SERVICES AND TRAUMA CARE NEEDS

A November 1989 Office of Technology Assessment (OTA) report found that although a well-organized emergency medical services (EMS) system enhances health care access in rural communities, not all states have developed EMS systems that extend to rural areas. For example, rural EMS systems are lacking adequate numbers of trained personnel, universal coverage by a communications network, and overall systems development. Specific problems include outdated communications equipment, "dead spots" in emergency radio coverage, difficulty of providers in maintaining specialized skills, old ambulances, and lack of air medical transportation.

Serious injuries pose a particularly difficult challenge to rural communities. In general, injuries occur just as often in rural communities as they do in urban areas. However, injury-related morbidity and mortality are often higher because of the time delays in reaching trauma victims on isolated roads, homes, or farms. The chance of a severely-injured individual dying in a rural area is three to four times higher than in urban areas. Fatalities from motor vehicle crashes, in particular, occur disproportionately in rural communities: Although more than half of fatal traffic accidents occur in rural areas, only one-third of the population lives there.

Most rural communities do not have health care facilities capable of caring for severely-injured patients. In those cases, such patients should be stabilized as quickly as possible and transferred to the nearest trauma center. Since time is critical, advanced prehospital care to stabilize trauma victims and established trauma protocols and agreements could help reduce death and disability in rural communities. As the OTA report concluded "A system that integrates all levels of hospital care within a state promotes regionalization and is likely to improve rural trauma patient outcomes."

URBAN TRAUMA SYSTEM NEEDS

Over the last three years, many urban trauma care systems have come under seige and are threatened by total collapse. An estimated 20 designated trauma centers in different parts of the country have withdrawn from regional trauma systems because of financial losses. Although trauma patients number only 600,000, a high proportion of them are uninsured and the cost of trauma care is two to four times higher than the average cost of care. Inadequate funding of trauma centers resulted in seven Level II centers dropping out of the Dade County, Florida, trauma system, leaving James Jackson Memorial Hospital as the County's only remaining trauma center. The Los Angeles trauma system is on the verge of collapse after 11 of the city's 23 trauma centers dropped out because of high uncompensated costs associated with providing trauma care—between $500,000 and $2 million annually per trauma center. Huntington Memorial Hospital in Pasadena lost $3.7 million last year and is the most recent trauma center to withdraw. San Diego's trauma system reported a loss of $6.8 million for 1988 for its 6 designated trauma centers.

In Chicago, four out of ten trauma centers have dropped out of the system. Houston's Hermann Hospital—one of only two level I

trauma centers in that city—decided to withdraw from the city's trauma system late last year after losing more than $7 million. The MedSTAR Trauma Center at the Washington Hospital Center in Washington, D.C. is threatening to close after sustaining losses of $8.9 million in 1989 associated with providing care to trauma and burn victims.

Undocumented persons continue to enter the United States causing financial strains on health and social services agencies in counties that border Mexico. Many trauma centers located in such border counties are experiencing serious financial losses because of large numbers of undocumented persons needing trauma care. Thirteen trauma centers in these communities incurred $8.2 million of bad debts last year as a result of providing care to critically injured patients who are undocumented.

A recent study on trauma care reimbursement found that trauma care represents an estimated $1.69 billion or 24 percent of the total uncompensated acute care, which costs $6.96 billion.

The issue of uncompensated trauma care must be addressed comprehensively and on a system-wide basis. At the same time, however, stop-gap measures are needed to preserve existing trauma systems and prevent more trauma centers from closing their doors.

LEGISLATIVE HISTORY

In 1973, the Emergency Medical Services Systems Development Act was enacted in order to improve the ability of communities to respond immediately and effectively to emergency medical crises. This law was intended to help local communities use existing resources to plan and develop comprehensive and integrated EMS systems in a 5-year sequence—from preliminary planning to fully functioning advanced systems. Systems established during the eight years that the grant program operated have been very successful in reducing death and disability.

In 1981, despite these successes and the fact that a majority of the 303 EMS regions designated under the Act had not yet completed their 5-year cycle, the Omnibus Budget Reconciliation Act of 1981 terminated the categorical grant program and shifted the funding into the Preventive Health and Health Services block grant.

In order to determine how EMS programs were faring under the block grant, Senators Cranston and Kennedy requested the General Accounting Office (GAO) to review and analyze the levels of support and proficiency of EMS systems throughout the country.

The results of the GAO's investigation were presented in a 1986 report, entitled "States Assume Leadership Role in Providing Emergency Medical Services" (HRD-86-132). The GAO found that, although States were assuming a more active leadership role in financing and regulating emergency medical services, there were areas in which gaps in emergency medical services remained and in which Federal actions and leadership were desirable. It made specific recommendations for Congressional action in these areas.

In particular, the GAO found that (1) many States lacked access to the most up-to-date information about EMS developments; (2) many States lacked coordination between agencies with oversight

of funds for EMS-related activities such as state transportation and emergency medical services agencies; (3) the 911 emergency telephone number was not uniformly available, particularly in rural communities; (4) the unavailability of funds for the start-up and operating costs of a 911 system was a major barrier to 911 implementation; (5) overcrowded radio frequencies and outmoded equipment hampered effective and efficient operation of EMS systems; and (6) economic and political factors were preventing the development of trauma systems.

A more recent OTA report on rural EMS came to similar conclusions. Specifically, the quality and availability of EMS varies greatly from state to state. Federal assistance for EMS declined sharply during the 1980s to approximately half of previous levels. Federal leadership in certain areas is still needed, particularly to provide incentives for states to initiate and implement planning efforts.

In the 100th Congress, the Committee reported legislation, S 10 (Sentate Committee Report 100-5[illegible] that was designed to implement the recommendations of the GAO report. The Senate was unable to complete action on the bill prior to adjournment.

III. Committee Views

Section 3. Establishment of programs with respect to trauma care

PART A—CLEARINGHOUSE ON EMERGENCY MEDICAL SERVICES AND TRAUMA CARE

Since the repeal of the EMS Systems Development Act and the advent of the 1981 block grant, the Federal role in collecting and disseminating information on the success and problems experienced by State and local agencies in EMS has been very limited. States are constantly upgrading their emergency and trauma care systems because of the emergence of new technologies and the development of new State and local initiatives. State officials surveyed by the GAO indicated that they could benefit greatly from a program for sharing information regarding a wide variety of EMS-related matters, such as practices and policies governing regulation of air ambulance services and the establishment of trauma systems, research assessing the most effective service delivery methods, and the generation of new revenues for EMS activities.

In order to promote dissemination of information, section 3 of the bill would establish a clearinghouse on EMS. The Committee urges the clearinghouse to foster the development of appropriate, modern emergency medical services and trauma care and, as judiciously as possible, foster the development of policies for the notification of family members of individuals involved in a medical emergency. The Committee believes that over three fiscal years, the clearinghouse could achieve self-sufficiency through subscriptions, user fees, or other means, and the bill thus would phase out federal support over that 3-year period.

PART B—TRAUMA CARE BLOCK GRANT

Central to reducing death and disability from trauma are the establishment and operation of trauma systems throughout the United States. Trauma care systems refer to systems of health care

delivery which coordinate and integrate prehospital EMS resources and hospital resources to help assure that optimal care is provided to traumatically injured patients. Such systems must provide for the identification and designation of trauma centers with specialized physicians, surgeons, and equipment immediately available on a 24-hour basis, a method to identify severe trauma victims in the pre-hospital phase, and policies to ensure that all major trauma victims are transported to trauma centers.

The Committee finds that in areas that have implemented trauma systems, the percentage of preventable deaths drops dramatically. For example, in San Diego, California, two years after the city implemented a regional trauma system, the rate of preventable deaths dropped to less than half of one percent. In Washington, D.C., a 50-percent reduction in trauma deaths over 5 years has been credited to the development of a trauma care system. Experts estimate that as many as 25,000 trauma deaths per year in the United States could be prevented with appropriate medical treatment. At least two studies show that with prompt, expert trauma care over 80 percent of the most seriously injured patients return to full-time productivity four years following the injury, with most regaining full activity within one year.

The Committee is concerned that, despite the documented effectiveness of regional trauma care systems, very few communities in the United States have developed such systems. In a March 1988 report, entitled "Trauma System Development", the National Highway Traffic Safety Administration of the Department of Transportation found that none of the five areas studied—Dade County, Florida; Allentown, Pennsylvania; Sacramento, California; Amarillo, Texas; and Bend, Oregon—had fully developed systems. In addition, a June 24, 1988, Journal of the American Medical Association article, entitled "Trauma Systems, Current Status—Future Challenges", reported that only two States had statewide coverage, that nineteen States and the District of Columbia had regional trauma systems which lacked one or more components of a complete system, and that the remaining 29 States had not yet initiated the process of trauma center designation.

The Committee finds that both economic and political factors hamper trauma system development. Competition between hospitals—which often see trauma center designation as a way to improve their image and status within the community—has stymied trauma system development in many communities. In other areas, the process of designation has become vulnerable to political pressures. The GAO concluded that, although States are in the "best position to overcome the barriers to trauma system development", most had not provided the necessary leadership—in part because of hospital industry concerns.

In order to help States overcome these barriers, the bill would require each State to submit to the Secretary a trauma care plan as part of its overall emergency medical services plan. The Committee does not intend that States set up independent trauma systems, but rather integrate trauma systems into existing emergency medical services systems. Each State plan would provide for the planning, development, and implementation of integrated regional

trauma care systems within a comprehensive emergency medical services system.

The plan would further be required to specify the public or private entity—at either the State or local level—that would designate trauma centers. The Committee believes that lead agencies must be given formal, legal authority for such activities.

The plan would also contain minimum standards and requirements for the designation of trauma centers and for the implementation of regional trauma care systems and would specify procedures for the accreditation and evaluation of trauma facilities. In addition, the plan would provide for the establishment of a trauma data reporting system and for the implementation of public education activities concerning injury prevention.

Trauma care system standards.—Section 1214(d)(1) would provide that states shall adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies that take into account existing national standards. The American College of Surgeons (ACS) and the American College of Emergency Physicians (ACEP) have developed such standards that are recognized by many trauma care experts as reflecting the state-of-the-art for quality trauma care and have already served as the basis for trauma system development in several States.

The Committee urges states to utilize the ACS and ACEP guidelines as guides for the development of their standards. However, the Committee also recognizes that some states have unique circumstances that would prevent their trauma systems from meeting or adhering to all aspects of the ACS and ACEP guidelines. For example, some hearing witnesses raised concerns that states need flexibility in developing trauma care standards because of variability in a state's resources, terrain, population density, and stage of development of emergency medical services systems.

The Committee is aware that severely injured children have unique needs and often require special equipment, facilities, and expertise. Thus, the Committee would expect the States, in implementing standards for facilities with specialized capabilities in the care of pediatric trauma patients, to take into account applicable guidelines established or endorsed by the American Academy of Pediatrics.

Although the Committee believes that states should make every attempt to implement the ACS and ACEP standards, states would be able to develop standards to meet their individual needs. The Committee wants to emphasize, however, that, as stated in paragraph 1214(d)(2) all standards must have as their primary goal and consideration ensuring the availability and high quality of trauma care. The Committee believes that the quality of care should be monitored through a hospital's Quality Assurance Program.

The Committee is concerned about reports in some states that pressures by special interests and other political concerns have resulted in trauma system standards that did not provide for quality patient care. Thus, 1214(d)(1) requires that the development of the standards be conducted in an open process and that all interested parties have an opportunity to participate. It would require states to consult with various medical, surgical and nursing specialty groups, hospital associations, EMS state and local directors, trauma

associations, and concerned advocates. In addition, the provision requires the state to conduct hearings on the proposed standards. The Committee believes that this process is critical to help ensure that the standards developed are in the best interest of the patients and that the trauma systems have the greatest chance of success.

For states that have existing standards, states must demonstrate that they developed standards in an open process, that they took into account the ACS and ACEP standards and that their systems provide for the highest possible quality of trauma care.

In order to assist states develop trauma care system standards, Section 1214(e) would require the Secretary to develop a model plan for the designation of trauma centers and for triage, transfer and transportation policies within one year. After the development of such a model plan, a state would be required to take it into account in the development and refinement of its standards.

The Secretary in developing a model plan shall involve all interested parties. It is the intent of this Committee that the development of this model will be an open process and that the Secretary shall carefully consider existing national standards developed by the American College of Surgeons and the American College of Emergency Physicians whose guidelines are viewed by many as reflecting the state-of-the-art in quality trauma care; by the American Academy of Pediatrics in reference to the care of the pediatric trauma patient; and by states that have developed effective and quality trauma systems.

The Secretary would also be required to consult with various nursing and medical groups that have special interest in trauma care such as surgeons, emergency physicians, pediatricians, pediatric surgeons, anesthesiologists, nurses, nurse anesthetists, primary care physicians, and others; state emergency medical services directors and emergency medical services associations; allied health care providers involved in trauma care; the United States Department of Transportation; hospital associations; rural health associations; trauma associations, and other concerned advocates or interested parties. It is the Committee's intent that the Secretary shall consider all licensed certified personnel who provide trauma care services to the extent of their qualifications in developing the model plan.

Section 1214(b)(3) sets forth requirements for minimum standards for the designation of different categories of trauma centers. In its March 1988 report, mentioned earlier, the Department of Transportation concluded that "the manner of trauma center designation affects a trauma system: the stronger the designation, the better the system is likely to be." Strong designation procedures not only categorize hospitals as meeting the necessary standards with a capacity to treat trauma victims but also specifically identify those trauma centers which are most able and most committed to doing so.

The Committee notes that designation is also important to ensuring maximal utilization of limited resources. In some areas designation of too many trauma centers has also been a problem preventing a cost-effective, efficient, and successful trauma system from operating.

The Committee does not intend, however, that this legislation be viewed as setting fixed and arbitrary federal limits on the number of trauma centers that may be designated in a State or region. State or local authorities are most qualified to determine the number of trauma centers that are necessary and appropriate within their jurisdictions. Such authorities shall designate trauma centers as provided in the State standards.

The ACS recommends a system of classifying trauma centers into one of three levels, depending on the availability of specialized surgical personnel and equipment, the frequency with which they perform surgical procedures related to trauma, and the presence of research and teaching activities. Level I and II centers for example, must have general surgeons and emergency medical personnel trained in trauma care, including neurosurgeons and orthopedic surgeons, available 24 hours a day. In addition, Level I centers must have a variety of surgical specialties in house 24 hours a day. Level III centers usually serve small communities or suburban settings. While these hospitals are generally unable to have available the same number and range of specialists as a Level I or II center, they are equally committed to providing high-quality trauma care and must rely on innovative use of resources and transfer agreements and protocols in providing trauma care services.

The Committee is aware that many rural areas do not have facilities that would meet the Level III standards as described by the ACS, and that national trauma care guidelines do not yet exist. Although the recently revised ACS guidelines specify many of the system and facility characteristics that must be assessed in any effort to improve trauma care in rural communities, there still is a need to provide a clear approach for raising the quality of trauma care in those areas. Thus, the Committee urges states to develop, publish and adopt standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to hospitals with resources appropriate to receive the injury.

The Committee believes that procedures for designating and trauma centers must include a rigorous evaluation process.

Use of State allotments.—The Committee bill would provide that each State use a minimum of 35 percent of its allocation for the purpose of planning, implementing, monitoring, and evaluating the operation of trauma care systems. In addition, each State would be required to use 35 percent of its allocation for the purpose of reimbursing certain financially-stressed hospitals with trauma centers for a portion of their uncompensated costs associated with trauma care. Each State would have the discretion to devote the remaining 30 percent to either of the two activities described above. In addition, the Secretary would be permitted to adjust the minimum percentages a State must spend for each of the two activities if the State demonstrates it is unable to use 35 percent of its allotment for one or the other activity. Because States and communities vary in the status of their trauma systems, the Committee believes that this approach would result in the States having appropriate flexibility to apply resources to the development or maintenance of trauma systems and centers.

With regard to trauma system development, each trauma care system supported under section 3 of the bill must meet the standards set forth in the State plan, including providing for the implementation of appropriate triage procedures and transfer and transportation policies; establishing criteria and procedures for the identification, designation of trauma centers; and conducting public education activities concerning injury prevention and obtaining access to emergency medical and trauma-care services.

With regard to reimbursement of trauma centers, the bill would require that in order to be eligible to receive reimbursement, trauma centers must serve communities covered by trauma systems. Generally, only Level I or Level II trauma centers would be eligible for such reimbursement. However, in rural communities, Level III trauma centers as specified by the State plan would also be eligible. The Committee recognizes that many rural areas do not have the personnel or financial resources to support trauma facilities. Yet, rural populations suffer a disproportionate number of deaths and disabilities due to trauma. Thus, Level III centers which have a demonstrated commitment to trauma care serve to link rural residents with Level I or Level II trauma centers.

The Committee is concerned that, without access to additional funding for trauma centers, many trauma systems will collapse. Providing financial relief to trauma centers in distress is necessary to preserve the integrity of many trauma systems. Inadequate funding of trauma centers has led many to withdraw in Dade County, Los Angeles, Chicago, Orange County (California), Houston, and Washington, D.C., among others. In general, the above-referenced March 1988 Department of Transportation study concluded that the problem of uncompensated care is a major disincentive to hospitals' participation in trauma systems.

The Committee notes, however, that the issue of uncompensated care is a major health policy issue that must be addressed comprehensively and on a system-wide basis for health-care providers. For example, uncompensated care is forcing emergency rooms, which would not receive any financial relief under this legislation, to be downgraded in Los Angeles; this could result in the lack of available emergency medical care for residents and employees in downtown Los Angeles.

The Committee recognizes that many trauma centers located in counties that border Mexico, face an additional financial challenge—caring for undocumented trauma victims. Many trauma centers in the border counties of Texas, Arizona, New Mexico and California, as well as Florida, are experiencing serious financial losses because of large numbers of undocumented persons needing trauma care. The burden of such uncompensated losses poses a threat to the economic viability of border area trauma centers. Therefore, to help ensure that the critical care provided by border area trauma care centers continues, the Committee recommends that the States involved give full consideration to these unique problems in making determinations for reimbursement for uncompensated trauma care under section 5(a) of the bill.

The Committee also recognizes that direct reimbursement to some trauma centers may provide incentives for the inappropriate transfer of patients who are not seriously injured. Thus, the Com-

mittee has included provisions—similar to those enacted in section 9121 of Public Law 99-272 with respect to Medicare hospitals—in order to prohibit inappropriate transfers. In addition, State plans must provide for periodic review of transfers and the auditing of such transfers determined to be inappropriate.

Reports by Secretary.—Section 1224 requires the Secretary to prepare and submit a report on the activities of the States in developing and implementing the trauma care program. Specifically, the report would be required to include an evaluation of state trauma system plans and standards. Using the data collected through state data reporting systems that is required to be provided to the Secretary, the Committee believes that the Secretary has a unique opportunity to determine which state plans and standards have resulted in the greatest reduction of preventable deaths from trauma. The Committee further believes that the injury control program at the Centers for Disease Control would be best qualified to conduct the analysis and review.

PART C—RURAL EMERGENCY MEDICAL SERVICES AND TRAUMA CARE

The Committee amendment establishes a new Part C of the Title XII of the Public Health Service Act. This provision would provide special assistance to rural communities, such as those identified in the State report on the availability of EMS in rural areas required by section 1216(b)(2), in order to help fill in gaps in their emergency medical services systems. It would also help ensure that they would be able to participate fully in regional trauma care systems.

Part C would provide that 15 percent of the total funding of the bill—$11.25 million if fully funded—would be set aside for grants aimed at filling in gaps in basic and advanced life support emergency medical services in rural communities. Priority would given to projects that are necessary in order to implement trauma care systems.

Funding could be used to support the recruitment, training, and retention of EMS personnel, to purchase and upgrade communications equipment, including 911 telephone systems, to improve transportation services, and to conduct public education activities concerning preventing injuries that are of special concern to rural communities.

The Committee is aware of new technology to enhance the capabilities of rural hospitals to stabilize and treat trauma victims. Decision-support electronic communications enable health professionals in a rural facility and professionals in far-away trauma centers to communicate vital information about the patient. Through such telecommunications, trauma center staff can review electrocardiograms, CT scans and other medical images, provide for the rapid and efficient searching of clinical databases and provide immediate professional consultation on the management of trauma patients. The Committee believes that this type of system would be an appropriate project to be funded under this program.

States would apply on behalf of individual communities but the funding would be targeted to the areas most in need. Since states would apply for the money, it is the Committee's expectation that they would have the discretion to define what constitutes a rural

community for these purposes. That definition would not necessarily have to be consistent with the definition used by the Medicare program.

Sec. 4. Requirement of certain studies relating to trauma care

The Committee is concerned that although trauma is the leading cause of death and disability in children and young adults, destroys the health, lives, and livelihoods of millions of people, and is the most costly of all major health problems, very little data are available about the long-term economic consequences of trauma. Knowledge about the chronic effects of injury on personal abilities in occupations and recreation and on social and psychological functioning is sorely lacking.

In order to establish an effective data collection base for evaluating the cost-effectiveness of trauma systems, section 6 would require the Secretary of HHS to conduct a comprehensive study on the long-term economic impact of trauma in the United States. The study would follow a multidisciplinary approach and draw on diverse fields such as epidemiology, statistics, biomedical engineering, behavioral sciences, health economics, and general economics in order to identify and evaluate the many factors that influence the impact and long-term outcome of a trauma incident.

Sec. 5. Coordination between State agencies

The GAO found that many State transportation departments and State health departments do not coordinate expenditures for EMS-related functions. State transportation departments receive federal highway safety funds from the Department of Transportation; State health departments generally received PHHS block grant monies from the Department of Health and Human Services.

The Committee is concerned that, as the GAO found in four out of six States, these State agencies do not communicate and coordinate with each other with respect to how each spends federal and State dollars on EMS. The Committee believes that providing representatives of each agency with the opportunity to participate in development of plans for EMS services, as section 3 of the Committee bill would provide for, would bring about better coordinated expenditures.

Sec. 6. Upgrading communications systems

The Committee believes that communications—between patient or other individuals on the scene and central dispatcher, between dispatcher and ambulance or other emergency vehicle, and between emergency vehicle and hospitals—are at the core of a successful EMS system.

The Committee is concerned that the GAO found that although the availability of the 911 emergency telephone number is essential for ensuring rapid access to the EMS system, more than 50 percent of the population of the United States still does not have access. Lack of access is particularly widespread in rural areas; for example, in the rural regions visited by the GAO, only two out of nine have complete coverage. The most common factors cited as barriers to providing a 911 system were start-up and operating costs.

The Committee is also concerned that lack of funds is preventing many communities from replacing and upgrading outmoded communications equipment that is essential for Advanced Life Support EMS systems. Federal funding under the PHHS block grant is prohibited from being used for such equipment purchases.

Section 6(a) would improve rural communities' abilities to implement and operate 911 systems, by specifying expressly that the Community Facilities Loan (CFL) program under the Farmers Home Administration may be used for 911 development and communications-equipment purchases. The Committee understands that this modification is consistent with the intent of the CFL program, which is designed to improve community facilities providing essential services to rural residents, including fire, health and rescue services. The Committee has been notified that the Senate Committee on Agriculture, Nutrition, and Forestry, which has jurisdiction over the CFL program, has no objection to this provision.

The GAO reported that interference due to overcrowded radio frequencies is hampering radio communications between ambulances and hospitals. The GAO found that 10 of the 18 local areas it surveyed reported unacceptable radio interference from other emergency and non-emergency users licensed to use the same channels. For example, in San Antonio, Texas, officials said that their emergency radio communications are frequently interrupted by licensed non-emergency use of electronic pagers.

Section 6(b) would require the Federal Communications Commission (FCC) to assess the current and future availability of radio frequency channels for EMS communications between ambulances and hospitals—both public and private—and to establish a plan which ensure that the needs of EMS systems would be adequately provided for in making future allocations and frequencies.

The Committee understands that the FCC has already undertaken a study of these matters and is developing a national assignment plan for recently allocated Public Safety radio frequencies. To the extent that the issues raised in paragraphs (1) and (2) of section 6(b) regarding the study of available frequencies and the establishment of a plan are sufficiently addressed in the FCC's ongoing study, the Committee does not intend that a separate effort be undertaken. However, the Committee does still intend that a separate report be submitted to Congress which contains the information requested as it pertains to emergency medical services communications. The Committee expects the FCC to include in its report a discussion of the potential need for protected frequencies for prehospital medical services.

IV. Committee Action

The Committee held hearings on S. 15 on July 25, 1989 (S. Hrg. 101-374). Testimony was received from Senators Alan Cranston and Sen. Albert Gore; Steven Kyler of Adamstown, Maryland; Dr. Charles C. Wolferth of Philadelphia, Pennsylvania; Dr. Jacek B. Franaszek of Hinsdale, Illinois; Dr. Howard R. Champion of Landover Maryland; Dr. Ralph W. Muller of Chicago, Illinois; and Dr. N. Mark Richards of Harrisburg, Pennsylvania.

S. 15 as amended by the Committee amendment was voted to be reported out of Committee on a voice vote on February 28.

V. Cost Estimate

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 15.
2. Bill title: Emergency Medical Services and Trauma Care Improvement Act of 1989.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on February 28, 1990.
4. Bill purpose: To amend the Public Health Service Act to improve emergency medical services and trauma care, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1991	1992	1993	1994	1995
Estimated authorization levels:					
Emergency medical services clearinghouse	1	(1)	(1)		
Trauma Care Grant Program	75	75	75		
Study on reimbursement of trauma centers by Medicaid	(1)				
Study on the long-term economic effects of trauma	1				
FCC emergency communications improvements study	(1)				
Total estimated authorization levels	77	75	75		
Estimated outlay levels:					
Emergency medical services clearinghouse	(1)	(1)	(1)	(1)	(1)
Trauma Care Grant Program	41	63	75	35	12
Study on reimbursement of trauma centers by Medicaid	(1)				
Study on the long-term economic effects of trauma	1	(1)	(1)		
FCC emergency communications improvements study	(1)				
Total estimated outlays	42	64	75	35	12

[1] Less than $500,000

Details in the table may not add to totals due to rounding.

The costs of this bill fall within budget functions 370 and 550.

Basis of estimate: This estimate assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Authorizations not stated in the bill are estimated by CBO. Outlays are estimated using spendout rates computed by CBO on the basis on recent program data.

S. 15 would establish a National Clearinghouse on Emergency Medical Services and Trauma Care. The bill provides an authorization of $500,000 in fiscal year 1991, $300,000 in fiscal year 1992, and $100,000 in fiscal year 1993 for this activity.

The bill would establish a trauma care block grant program that would allot funds to states on the basis of their population and area. In addition, the bill would authorize the establishment of a competitive grant program in order to improve states' rural emergency and trauma care systems. S. 15 provides $75 million in each of fiscal years 1991 to 1993 for these activities.

S. 15 would require the Secretary of Health and Human Services (HHS) to conduct two studies. The first study, to be completed

within one year of enactment, would identify state medicaid policies concerning the reimbursement of trauma centers. The second study would pertain to the long-term economic effects of trauma and would be completed within three years of the enactment of this bill. Based an information provided by HHS officials, CBO estimates that the study on medicaid reimbursement policies would cost less than $500,000 and that the study on the long-term economic effects of trauma would cost approximately $1 million in fiscal year 1991.

The Federal Communications Commission (FCC) would be required to complete a study on the availability of radio frequency channels for emergency medical services communications. In addition, the FCC would be required to establish a plan to ensure that the communication requirements for emergency medical services are met. CBO estimates that these activities could cost up to $300,000 in fiscal year 1991.

6. Estimated cost to State and local government: After fiscal year 1991, states receiving trauma care grants must contribute not less than $1 in non-federal funds for each $3 of federal funds. If the entire $75 million authorized in 1992 were appropriated and allocated, the maximum amount that applicants would have to make available would be $25 million.

States participating in the trauma care grant program may spend up to five percent of funds received each fiscal year to administer the program. States would have to support additional administrative costs from non-federal funds.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Karen Graham and Doug Criscitello.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

VI. Regulatory Impact

In states which receive federal grant funds, design emergency medical system plans and implement such systems, most hospitals would be affected to some degree by existence of these systems. Their patterns of patient transfer, or their acceptance of patient transfer, will depend, in part, on the agreements reached within that state for triage, transfer, and care of trauma victims. Only those hospitals functioning as trauma centers would actually be required to comply with the standards set forth in the legislation. This would include approximately 250–500 hospital nationwide. Ambulance companies in such states would similarly be affected by the existence of these systems.

The economic impact on businesses, consumers, and individuals is not expected to be widespread. The impact of any additional caseload on hospitals which are designated as trauma centers will be determined by reimbursement policies. Hospitals so designated may have expenditures associated with the modifications necessary to comply with the standards established by federal regulation and by the state plan. Money granted to the states through the bill would be offsetting.

This legislation is anticipated to have no impact on personal privacy. The data collection provisions contained in the bill do not require personal identifiers.

There would be some modest increase in paperwork associated with the initiative in that hospitals will be subject to reporting requirements regarding trauma patients. The time and paperwork involved would be dependent in part on the reporting approaches as development by the states and on the federal regulations which apply to trauma centers and systems.

VII. Section-by-Section Analysis

SECTION 1—SHORT TITLE AND REFERENCE

Section 1 provides that the Act may be cited as the "Emergency Medical Service and Trauma Care Improvement Act of 1989."

SECTION 2—FINDINGS

Section 2 of the bill establishes Congressional findings regarding the extent and cost of injury in the United States.

SECTION 3—ESTABLISHMENT OF PROGRAMS WITH RESPECT TO TRAUMA CARE

Section 3 of the bill amends the Public Health Service Act to add a new title XII—Trauma Care—containing four parts and new sections 1201 through 1242.

Part A—General Authority and Duties of Secretary

Clearinghouse on emergency medical services

Section 1201 of the Act authorizes the Secretary of HHS to provide by contract for the establishment and operation of a National Clearinghouse on Emergency Medical Services. The duties of the Clearinghouse will be to—

(1) foster the development of appropriate, modern emergency medical services and trauma care (including the development of polices for the notification of family members of individuals involved in a medical emergency) through the sharing of information among agencies and individuals involved in planning, furnishing, and studying such services and care;

(2) collect, compile, and disseminate information on the achievement of, and problems experienced by, State and local agencies and private entities in providing emergency medical services and trauma care and, in so doing, give special consideration to the unique needs of rural areas;

(3) provide technical assistance relating to emergency medical services and trauma care to State and local agencies; and

(4) sponsor workshops and conferences on emergency medical services and trauma care.

A contract entered into by the Secretary under this section may provide that the Clearinghouse shall charge fees or assessments in order to defray, and beginning with FY 1991, to cover, the costs of operating the Clearinghouse. The authority of the Secretary to

enter into contracts under this section shall be to such extent or in such amounts as are provided in appropriation acts.

Section 1201 authorizes appropriations to carry out the section of $500,00 for the later of FY 1991 or the first year thereafter for which funds are appropriated under the section $300,000 for the later of FY 1992 or the second year for which funds are so appropriated, and $100,000 for FY 1993 or the third year for which funds are so appropriated.

General duties

Section 1202 of the Act as added by the bill authorizes the Secretary to make into grants and enter into cooperative agreements and contracts in order to—

(1) conduct and support research, training, evaluations, and demonstration projects on emergency medical services and trauma care;

(2) provide technical assistance to State and local agencies; and

(3) establish guidelines for the development of uniform State data reporting systems.

Part B—Grants with Respect to Modifications of State Plans

Establishment of program

Section 1211 of the Act as added by the bill directs the Secretary to make payments for each fiscal year to each State from the amounts appropriated for that year. Any amount paid to a State for a fiscal year and unobligated at the end of that year shall remain available for the next fiscal year to the States.

Use of allotments

Section 1212 of the Act as added by the bill describes the permissible uses of allotments to States under this block grant. A State must use at least 35 percent of its annual allotment to pay the costs of planning, implementing, monitoring, and evaluation the operation of country, regional, or State trauma care systems. Each such trauma care system supported with amounts under this authority shall—

(A) meet standards and requirements established under the State plan submitted under section 1214;

(B) provide for the use of triage procedures by paramedics, emergency, medical technicians, and other emergency care providers to assess the severity of injury incurred by trauma patients;

(C) provide for the use of appropriate transportation and transfer policies, including those referenced in section 1214(c) to ensure the delivery of patients to designated trauma centers. Such centers will include facilities with specialized capabilities and expertise in the care of pediatric trauma patients, and other facilities within and outside the jurisdiction of such system. Transportation and transfer policies will ensure that

only individuals appropriately identified as trauma patients are transferred to designated trauma centers;

(D) improve or establish injury prevention programs; and

(E) establish criteria and procedures in accordance with the State plan required under section 1214 for the identification and designation of trauma centers to participate in the trauma care system.

Section 1212(b) required that at least 35 percent of a State's allotment be used by the State to reimburse designated trauma centers for the portions of the uncompensated trauma care expenditures of such centers (including uncompensated professional services) as the State considers appropriate. In order to receive such reimbursement, a designated trauma center must—

(A) be a center that meets the standards and requirements established by the State under the State plan required under section 1214, and meets the guidelines for level I or level II trauma centers or in the case of rural communities, a level III trauma center specified by the State plan;

(B) serve an area in which the procedures and policies described in section 1212(a) (1) and (2) above have been implemented; and

(C) maintain its designation as a designated trauma center throughout the fiscal year for which such reimbursement is provided.

Section 1212(c) provides that, after the application of subsections (a) and (b) of section 1212 for a fiscal year, the amount remaining from a State's allotment for such year may be used for any purposes for which funds are required to be used under paragraphs (1) and (2).

Section 1212(d) provides for adjustments in the use of allotments by a State. A State may be permitted to use more than 65 percent of its allotment for planning, implementing, monitoring, and evaluating the operation of trauma care systems if it can be demonstrated that it is unable to use the full required 35 percent of its allotment for reimbursement of uncompensated trauma care services. Similarly, a State may be permitted to use less than the required 35 percent of its allotment for planning, implementing, monitoring, and evaluating the operation of trauma systems if it can be demonstrated that the State does not need to use 35 percent for such purposes.

Section 1212(e) provides that not more than 5 percent of a State's allotment for a year may be used for administering the program. The State must pay any remaining costs of administration from non-Federal sources.

Requirement of matching funds for fiscal years subsequent to fiscal year 1991

Section 1213 of the Act as added by the bill provides that in each fiscal year after 1991, States that receive payments under section 1211(a) must agree to contribute not less than $1 for each $3 of Federal funds to carry out the programs described in section 1212. Non-federal contributions may be in cash or in kind, including plant, equipment or services.

Requirements with respect to carrying out purpose of allotments

Section 1214 of the Act as added by the bill requires each State, for each fiscal year beginning with FY 1991, to submit the trauma care component of the State emergency medical services plan to the Secretary. If the State has not completed the State plan in fiscal year 1991, the State may provide an interim plan or description of efforts made on the plan.

Section 1214(b) requires that each State plan shall—

(1) specify that the state plan will be implemented by the principal State agency with respect to emergency medical services;

(2) specify the state or local public agency or designated trauma care regions and trauma centers within the State;

(3) contain minimum standards and requirements for the designation of trauma centers including facilities for the care of pediatric trauma patients by such entity, including standards and requirements for—

(A) the numbers and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury;

(B) the resources and equipment needed by such facilities; and

(C) rehabilitation services for trauma care patients;

(D) the provision of assurances that such center may not refuse the transfer of a trauma patient because of the ability to pay for care.

(4) contain standards and requirements for the implementation of regional trauma care systems within a comprehensive, integrated regional emergency medical services system, including standards and guidelines (consistent with provisions of section 1867 of the Social Security Act) for triage and transportation of all trauma patients;

(5) contain standards and requirements of triage and transport of pediatric trauma patients, prior to care in trauma centers and in facilities with specialized capabilities and expertise in the care of pediatric trauma patients;

(6) specify procedures for the evaluation of trauma facilities and facilities with specialized capabilities and expertise in the care of the pediatric trauma patient, and trauma care systems;

(7) provide that the standards address the special needs of rural communities;

(8) provide for the establishment in the State of a central data reporting and analysis system to identify severely injured trauma patients, identify the cause and outcome of the injury, identify the total amount of uncompensated trauma care expenditures made for each fiscal year by each trauma center and for other purposes;

(9) provide for periodic reviews of transfers;

(10) improve or establish injury prevention programs and conduct public education activities concerning injury prevention and obtaining access to trauma care; and

(11) with respect to the requirements in (2) through (10), provide assurances of coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

Section 1214(c) provides that appropriate transfer policies referred to in section 1214(b)(4) include the following requirements:

(A) *Medical Screening Requirements.*—In the case of a hospital emergency department, if an individual comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the emergency department's capability to determine whether or not an emergency medical condition (as defined in section 1867(e)(1) of the Social Security Act) exists or to determine if the individual is in active labor (as defined in section 1867(e)(2) of the Social Security Act).

(B) *Necessary Stabilizing Treatment for Emergency Medical Conditions and Active Labor.*—If an individual comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

(I) within the staff and facilities available at the hospital, for such further medical examination and treatment as may be required to stabilize the medical condition or to provide for treatment of the labor; or

(II) for transfer of the individual to another medical facility in accordance with (C) below.

A hospital shall be considered to meet requirements of (I) and (II) with respect to an individual if the hospital offers the individual the further medical examination and treatment in (I) or the transfer to another facility in (II) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment or to the transfer.

(C) *Restricting Transfers until Patient Stabilizes.*—If a patient at a hospital has an emergency condition which has not been stabilized (as defined in section 1867(e)(4)(B) of the Social Security Act) or is in active labor, the hospital may not transfer the patient unless—

(I) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or a physician or other qualified medical personnel has signed a certification that, based on the risks and benefits to the patient, and based on available information at the time, the medical benefits expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

(II) the transfer is an appropriate transfer (as defined below) to that facility.

If a patient at a hospital has an emergency medical condition that has been stabilized, the hospital may transfer the patient but only by means of an appropriate transfer. A transfer to a medical facility is an appropriate transfer if—

(I) the receiving facility has available space and qualified personnel for treatment of the patient, and has agreed to accept the patient and to provide appropriate medical treatment;

(II) the transferring hospital provides the receiving facility with appropriate medical records (or copies) of the examination and treatment at the transferring hospital;

(III) the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer; and

(IV) the transfer meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the patient.

(D) *Call Schedules.*—In the case of a hospital with an emergency department, the hospital shall provide a call schedule listing appropriate medical specialists that will be immediately available for duty to provide ongoing, definitive treatment to a patient after the initial examination by emergency physicians.

Section 1214(d) requires that states adopt standards for the designation of trauma centers, and for triage, transfer and transportation policies. In developing such standards, States must take into account existing national standards, consult with trauma care experts, conduct public hearings and, beginning in 1992, take into account the model plan as described in 1214(e).

Section 1214(d)(2) states that the highest quality of trauma care shall be the primary goal of State standards.

Section 1214(d)(3) requires that in the case of a State that has adopted standards prior to the enactment of this title, the State must demonstrate that the State standards provide for the highest possible quality of trauma care and that the State took into account existing national standards and consulted with trauma care experts.

Section 1214(d)(4) provides that the Secretary shall deny payments if the Secretary determines that the State has not taken into account existing national standards or the model plan, beginning in 1992, and the State has not developed the standards in an open process.

Section 1214(e) directs the Secretary to develop a model plan for the designation of trauma centers and for triage, transfer and transportation policies within one year of the date of enactment. The plan may be adopted for guidance by States. The plan must take into account existing national standards and existing State plans, be developed in consultation with trauma care experts, and include standards for the designation of rural health facilities and hospitals and for triage, transfer and transportation policies as they relate to rural areas, including both non-metropolitan areas and frontier areas with populations of less than 6,000 per square mile.

Requirement of annual report by designated trauma centers

Section 1215 of the Act as added by the bill requires States to require each designated trauma center in the State to provide to the central data reporting system a report that specifies the

number of severely-injured trauma patients, the average length of hospital stay, the outcomes of severely-injured trauma patients and their discharge disposition, the total amount of uncompensated trauma care expenditures and the number of patients transferred inappropriately.

Requirement of provision of certain information to Secretary

Section 1216 of the Act as added by the bill requires each State to provide the Secretary with information collected through its central reporting system as required through section 1214(b)(8) and information regarding rural areas in which there is no 911 telephone system, no basic life-support emergency medical services system and no advanced life-support EMS system.

Restrictions on use of payments

Section 1217 of the Act as added by the bill describes the prohibitions on uses of funds under this authority. In general, the State may not use allotments to—

(A) make cash payments to intended recipients of services;

(B) purchase or improve land, purchase, construct, or permanently improve any building or other facility, or purchase major medical equipment unless the use of the amount involved is specifically designed to enhance the overall trauma system; or

(C) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

The Secretary may waive the limitation in (B) on the request of the State if the Secretary finds that section 1212 could not otherwise be carried out.

Requirement of reports by States

Section 1218 of the Act as added by the bill requires that each State must prepare and submit to the Secretary an annual report in order to obtain a record and description of how payments were expended and whether such expenditures were in accordance with the purpose of the program involved. The State must agree to make copies of such report available for public inspection. The Comptroller General of the United States shall periodically evaluate State expenditures in order to assure that such expenditures are consistent with the provisions of the program.

Requirement of submission of application containing certain agreements and assurances

Section 1219 of the Act as added by the bill provides that each State, through the chief executive officer of that State, must submit to the Secretary an application containing agreements in accordance with section 1212 through section 1218 and that otherwise provides such agreements, assurances and information as the Secretary determines.

Amounts of allotments

Section 1220(a) of the Act as added by the bill authorizes the formula by which funds under this authority will be alloted to States. Eighty percent of the amount appropriate will be allotted to each

State on the basis of its population compared to population of all States, and 20 percent will be allotted on the basis of the square mileage of each State compared to the square mileage of all States. No State shall receive an allotment that is three times the greater of the amount the State would otherwise receive if a State's allotment were determined solely on the basis of its population or of the minimum amount.

Section 1220(b) provides that the minimum allotment of a State each year will be not less than the greater of $250,000 or one-half of 1 percent of the total amount appropriated. If the total amount appropriated is less than $25 million, the Secretary shall allot 25 percent of the amount equally among all States and allot the remaining amount according to a formula that targets funds to States with the greatest commitment to trauma systems and that have the greatest need.

Section 1220(c) provides for the reallotment of any appropriated funds under this authority which are not used by one or more States to the remaining States.

Failure to comply with agreements

Section 1221 of the Act as added by the bill provides that the Secretary may require a State to repay payments if the Secretary determines that certain expenditures were not made in accordance with agreements made by the State.

Prohibition against certain false statements

Section 1222 of the Act as added by the bill prohibits a person from knowingly making any false statements in connection with the furnishing of items or services with payments made under section 1211(a).

Technical assistance and provision by Secretary of Supplies and Services in lieu of grant funds

Section 1223 of the Act as added by the bill directs the Secretary, if requested by a State, to provide such State with technical assistance with respect to the planning, development, and operation of any program under this authority. The Secretary, if requested by a State, may provide supplies, equipment, and services in order to assist such State in carrying out section 1211(b). The fair market value of such supplies, equipment and services will be deducted from the State's payments under section 1211(a).

Report by Secretary

Section 1224 of the Act as added by the bill directs the Secretary to prepare and submit to the appropriate Committees of Congress by February 1, 1993, a report on the activities of the States carried out under this authority. Such report may include any recommendations for appropriate administrative and legislative initiatives and shall include an evaluation of the trauma system plans and their respective data, recommendations regarding trauma system plans and standards that result in the most favorable patient outcomes, and recommendations regarding modifications of the model State plan.

Part C—Rural Emergency Medical Services and Trauma Care

Improving rural emergency medical services and trauma care

Section 1231 of the Act as added by the bill establishes a competitive grant program to improve rural emergency medical services. States may apply for funding on behalf of individuals, organizations, or governmental entities. Priority for grants will be given to projects aimed at filling gaps in basic and advanced life support emergency medical services in rural communities, projects that are necessary for communities to develop trauma care systems, and to States and communities that have large rural populations.

Grants may be used to support rural emergency medical services systems, recruit and train of EMS personnel, improve communications equipment relating to EMS, improve transportation services for medical emergencies, and conduct public education activities concerning prevention.

Part D—General Provisions

Definitions

Section 1241 of the Act as added by the bill defines five terms used in this title: "Designated Trauma Center", "Plan for the Provision of Emergency Medical Services", "State", "Trauma Care Component of the Plan for the Provision of Emergency Medical Services", and "Uncompensated Trauma Care Expoenditures".

Funding

Section 1242 of the Act as added by the bill authorizes appropriations of $75 million for each FY 1991 through 1993, for allotments to States under this authority. Of the amounts appropriated, 5 percent shall be made available to carry out Part A, 80 percent shall be made available to carry out Part B and 15 percent shall be made available to carry out Part C.

SECTION 4—REQUIREMENT OF CERTAIN STUDIES RELATING TO TRAUMA CARE

Section 4 provides for the Secretary to conduct two studies concerning trauma care. One study shall assess the adequacy and appropriateness of reimbursements under title XIX of the Social Security Act (Medicaid); the second study shall include a comprehensive multidisciplinary study of the long-term economic effects of incidences of trauma. The Secretary shall report the results of the first study within 1 year after the date of enactment and report the results of the third study within 3 years.

SECTION 5—COOPERATION BETWEEN STATE AGENCIES

Section 5(a) of the bill amends section 1905(c) of the PHS Act to require that the chief officer of a State, applying for an allotment under the Preventive Health and Health Services block grant, certify that the State agrees to provide the State officer responsible for the administration of the State highway safety program with an apportunity to—

(A) participate in the development of any State plan relating to emergency medical services, as such a plan relates to highway safety, including the State plan required by section 1910B of the Act; and

(B) review and comment on any proposal by any State agency to use any Federal grant or Federal payment received by the State for the provision of emergency medical services as such proposal relates to highway safety.

Section 5(b) of the bill amends section 402(b) of title 23, U.S. Code—Highway Safety Program—to provide that the Secretary of Transportation shall not approve any State highway safety program which does not provide procedures ensuring that State officials who are responsible for administration, planning, and coordination of emergency medical services within the State have the opportunity to—

(i) participate in the development of the State highway safety program as such program relates to emergency medical services;

(ii) provide advice on the development and implementation of those provisions of the State highway safety program related to emergency medical services; and

(iii) review, and comment on, any proposals to use funds provided to the State under this highway safety program for emergency medical services.

SECTION 6—IMPROVING COMMUNICATIONS SYSTEMS

Section 6(a) of the bill amends section 306(a)(1) of the Consolidated Farm and Rural Development Act to provide that water and waste facility loans and grants may be used for the installation or improvement of emergency telephone service, and communications equipment for emergency medical services.

Section 6(b) of the bill requires the Federal Communications Comission, not later than 1 year after the date of enactment of this bill, to—

(1) complete a study of the availability of radio frequency channels for emergency medical services communications;

(2) establish a plan to ensure that the needs of emergency medical services communication (including effective prehospital communications) shall be adequately provided for in the allocation of frequencies for public safety; and

(3) prepare and submit, to the appropriate Congressional Committees, a report containing—

(a) the results of the study and plan relating to emergency medical services communications; and

(b) to the maximum feasible extent, a description of the types of communications between ambulances and hospitals, including both public and private ambulances and hospitals.

SECTION 7—EFFECTIVE DATE

Section 7 provides that the effective date of this bill shall be October 1, 1990, or the date of the enactment, whichever occurs later.

VIII. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change in proposed is shown in roman):

Public Health Service Act

* * * * * * *

TITLE XIX—BLOCK GRANTS

Part A—Preventive Health and Health Services Block grant

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APPLICATION AND DESCRIPTION OF ACTIVITIES

Sec. 1905. (a) In order to receive an allotment for a fiscal year under section 1902 each State shall submit an application to the Secretary. Each such application shall be in such form and submitted by such date as the Secretary shall require. Each such application shall contain assurances that the legislature of the State has complied with the provisions of subsection (b) and that the State will meet the requirements of subsection (c).

(b) After the expiration of the first fiscal year in which a State receives an allotment under section 1902, no funds shall be allotted to such State for any fiscal year under such section unless the legislature of the State conducts public hearings on the proposed use and distribution of funds to be provided under section 1903 for such fiscal year.

(c) As part of the annual application required by subsection (a), the chief executive officer of each State shall certify that the State—

(1) agrees to use the funds allotted to it under section 1902 in accordance with the requirements of this part;

(2) agrees to establish reasonable criteria to evaluate the effective performance of entities which receive funds from the allotment of the State under this part and procedures for procedural and substantive independent State review of the failure by the State to provide funds for any such entity.

(3) agrees to permit and cooperate with Federal investigations undertaken in accordance with section 1907;

(4) has identified those populations, areas, and localities in the State with a need for the services for which funds may be provided by the State under this part;

(5) agrees that Federal funds made available under section 1903 for any period will be so used as to supplement and increase the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs and activities for which funds are provided under that section and will in no event supplant such State, local, and other non-Federal funds; [and]

(6) has in effect a system to protect from inappropriate disclosure patient and sex offense victim records maintained by the State in connection with an activity funded under this part or by any entity which is receiving payments from the allotment of the State under this part[.]; *and*

"(7) agrees to provide the officer of the State government responsible for the administration of the State highway safety program with an opportunity to—

"(A) participate in the development of any plan by the State relating to emergency medical services, as such plan relates to highway safety, including the State plan required by section 1910B; and

"(B) review and comment on any proposal by any State agency to use any Federal grant or Federal payment received by the State for the provision of emergency medical services as such proposal relates to highway safety.".

The Secretary may not prescribe for a State the manner of compliance with the requirements of this subsection.

(d) The chief executive officer of a State shall, as part of the application required by subsection (a), also prepare and furnish the Secretary (in accordance with such form as the Secretary shall provide) with a description of the intended use of the payments the State will receive under section 1903 for the fiscal year for which the application is submitted, including information on the programs and activities to be supported and services to be provided. The description shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the description and after its transmittal. The description shall be revised (consistent with this section) throughout the year as may be necessary to reflect substantial changes in the programs and activities assisted by the State under this part, and any revision shall be subject to the requirements of the preceding sentence.

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"TITLE XII—TRAUMA CARE

"PART A—GENERAL AUTHORITY AND DUTIES OF SECRETARY

"SEC. 1201. CLEARINGHOUSE ON EMERGENCY MEDICAL SERVICES AND TRAUMA CARE.

"(a) ESTABLISHMENT.—The Secretary shall by contract provide for the establishment and operation of a National Clearinghouse on Emergency Medical Services and Trauma Care (hereinafter referred to in this title as the 'Clearinghouse').

"(b) DUTIES.—The Clearinghouse shall—

"(1) foster the development of appropriate, modern emergency medical services and trauma care (including the development of policies for the notification of family members of individuals involved in a medical emergency) through the sharing of information among agencies and individuals involved in planning, furnishing, and studying such services and care;

"(2) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing emergency medical services and trauma care and, in so doing, give special consideration of the unique needs of rural areas;

"(3) provide technical assistance relating to emergency medical services and trauma care to State and local agencies; and

"(4) sponsor workshops and conferences on emergency medical services and trauma care.

"(c) FEES AND ASSESSMENTS.—A contract entered into by the Secretary under this section may provide that the Clearinghouse shall charge fees or assessments in order to defray, and beginning with fiscal year 1991, to cover, the costs of operating the Clearinghouse.

"(d) AUTHORITY TO ENTER INTO CONTRACTS.—The authority of the Secretary to enter into contracts under this section shall be to such extent or in such amounts as are provided in Appropriation Acts.

"(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $500,000 for the later of fiscal year 1991 or the first fiscal year thereafter for which funds are appropriated under this section, $300,000 for the later of fiscal year 1992 or the second fiscal year after fiscal year 1991 for which funds are so appropriated, and $100,000 for fiscal year 1993 or the third fiscal year after fiscal year 1991 for which funds are so appropriated.

"SEC. 1202. GENERAL DUTIES.

"(a) IN GENERAL.—The Secretary shall—

"(1) conduct and support research, training, evaluations, and demonstration projects with respect to emergency medical services and trauma care systems;

"(2) provide to State and local agencies technical assistance relating to emergency medical services and trauma care systems; and

"(3) establish guidelines for the development of uniform State data reporting systems as described in section 1214(b)(8).

"(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

"PART B—GRANTS WITH RESPECT TO MODIFICATIONS OF STATE PLANS

"SEC. 1211. ESTABLISHMENT OF PROGRAM.

"(a) REQUIREMENT OF ALLOTMENTS FOR STATES.—

"(1) IN GENERAL.—Subject to section 1242(b), the Secretary shall for each fiscal year make an allotment for each State in an amount determined in accordance with section 1220.

"(2) APPLICATION.—The Secretary shall make payments each fiscal year to each State from the allotment for the State if the Secretary approves for the fiscal year involved an application submitted by the State pursuant to section 1219.

"(b) AVAILABILITY.—Any amount paid to a State for a fiscal year and remaining unobligated at the end of such year shall remain

available for the next fiscal year to such State for the purposes for which such amount was paid.

"SEC. 1212. USE OF ALLOTMENTS.

"(a) PLANNING, IMPLEMENTING, ETC.—Not less than 35 percent of the total amount paid to a State under section 1211 for a fiscal year shall be used by a State to pay the costs of planning, implementing, monitoring, and evaluating the operation of, county, regional, or State trauma care systems. Such funds shall be administered by the head of the State agency or office responsible for the planning and coordination of emergency medical services system in the State. Each trauma care system supported with amounts made available under this subsection shall –

"(1) meet the standards and requirements established under the State plan submitted under section 1214;

"(2) provide for prehospital triage by paramedics, emergency medical technicians, and other emergency care providers to assess the severity of injury incurred by trauma patients;

"(3) provide for appropriate transportation and transfer policies, including those referenced in section 1214(c), to ensure the delivery of patients to designated trauma centers, including facilities with specialized capabilities and expertise in the care of pediatric trauma patients, and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers;

"(4) improve or establish injury prevention programs and conduct public education activities concerning obtaining access to emergency medical services and trauma care; and

"(5) establish criteria and procedures, in accordance with the State plan required under section 1214, for the identification and designation of trauma centers to participate in the trauma care system.

"(b) TRAUMA CARE EXPENDITURES.—Not less than 35 percent of the amount available for a fiscal year to a State from the total amount paid to the State under section 1211 for such fiscal year shall be used by the State to reimburse designated trauma centers for such portions of the uncompensated trauma care expenditures of such centers (including uncompensated professional services) as the State considers appropriate. In order to receive reimbursement for uncompensated trauma-care expenditures under this subsection, a designated trauma center shall—

"(1) be a center that—

"(A) meets the standards and requirements established by the State in accordance with the State plan required under section 1214; and

"(B) meets the guidelines for level I or level II trauma centers or in the case of rural communities, a level III trauma center as specified by the State plan required under section 1214;

"(2) serve an area in which the procedures and policies described in paragraphs (1) and (2) of subsection (a) have been implemented; and

"(3) maintain its designation as a designated trauma center througout the fiscal year for which reimbursement is provided under this subsection.

"(c) REMAINING AMOUNTS.—After the application of subsections (a) and (b) for a fiscal year, the amount remaining available for such fiscal year to a State from the total amount paid to the State under section 1211 for such fiscal year may be used for any purposes for which funds are required to be used under such subsections.

"(d) ADJUSTMENTS IN USE OF AMOUNTS AND ADMINISTRATION.—

"(1) ADJUSTMENTS.—The percentage of the total amount paid to a State under section 1211 for a fiscal year that is required by subsection (a) to be used for the uses specified in such subsection may be adjusted by the Secretary in order to—

"(A) permit the State to use for such uses such greater proportion of such amount as the Secretary determines, based upon a demonstration by the State of the extent to which the State is unable to use 35 percent of such amount for reimbursements under subsection (b), that the State is unable to use for such reimbursements; or

"(B) permit the State to use for such uses such lesser proportion of such amount as the Secretary determines, based on a demonstration by the State of the extent to which the State does not need to use 35 percent of such amount for such uses in order to carry out adequately during such fiscal year the activities described in subsection (a), that the State needs to use for such uses.

"(e) ADMINISTRATIVE COSTS.—Not more than 5 percent of the total amount paid to a State under section 1211 for a fiscal year may be used for administering the funds made available under section 1211. The State shall pay from non-Federal sources the remaining costs of administering such funds.

"SEC. 1213. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FISCAL YEAR 1991.

"(a) IN GENERAL.—

"(1) PROHIBITION.—The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purposes described in section 1212, to make available non-Federal contributions (in cash or in kind under subsection (b)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in payments from the allotment for such fiscal year.

"(2) LIMITATION ON CONDITIONS.—With respect to an allotment under section 1211(a) for a State for fiscal year 1991, the Secretary may not require the State to make non-Federal contributions as a condition of receiving payments from the allotment.

"(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Gov-

ernment, may not be included in determining the amount of such non-Federal contributions.

"SEC. 1214. REQUIREMENTS WITH RESEPCT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

"(a) STATE PLAN.—

"(1) TRAUMA CARE COMPONENT.—For each fiscal year, beginning with fiscal year 1991, each State shall submit the trauma care component of the State emergency medical services plan (hereafter in this section referred to as the 'State plan') to the Secretary.

"(2) INTERIM PLAN.—For fiscal year 1991, if a State has not completed the State plan, such State may provide, in lieu of a completed plan, an interim plan or description of efforts made toward the completion of the plan.

"(b) REQUIREMENTS OF PLAN.—Each State plan shall—

"(1) specify that the modifications required pursuant to paragraphs (2) through (10) will be implemented by the principal State agency with respect to emergency medical services or by the designee of such agency;

"(2) specify the State or local public agency or private entity that will designated trauma care regions and trauma centers in the State;

"(3) contain minimum standards and requirements for the designation of different categories of trauma centers (including facilities with specified capabilities and expertise in the care of the pediatric trauma patient) by such agency or entity, including standards and requirements for—

"(A) ensuring that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury which, in the case of level I or level II trauma centers, include the number and types of trauma patients for whom such centers must provide care in order to;

"(B) the resources and equipment needed by such centers;

"(C) the availability of rehabilitation servcies for trauma patients; and

"(D) the provision of assurances that such centers may not refuse the transfer of a trauma patient because the patient is unable to pay for the case that the patient requires;

"(4) contain standards and requirements for the implementation of regional trauma care systems, including standards and guidelines (consistent with the provisions of section 1867 of the Social Security Act (42 U.S.C. 1935d(d) and subsectdion (c) of this section) for medically directed triage and transportation of trauma patients;

"(5) contain standards and requirements for medically directed triage and transport of severely injured children to facilities with specified capabilities and expertise in the care of the pediatric trauma patient;

"(6) specify procedures for the evaluation of designated trauma centers (including facilities described in paragraph (5)) and trauma care systems;

"(7) provide that the standards and requirements described in paragraphs (3) and (4) address the special needs and problems of rural communities;

"(8) provide for the establishment in the State of a central data reporting and analysis system for—

"(A) identifying severely injured trauma patients with regional trauma care systems in the State;

"(B) identifying the nature and cause of severe injuries, and if known, factors contributing to the injury;

"(C) identifying patient outcomes;

"(D) monitoring trauma care resources (including prehospital care) with a regional trauma care system (including relevant rehabilitation information);

"(E) identifying the total amount of uncompensated trauma care expenditures made for each fiscal year by each trauma center in the State; and

"(F) identifying patients transferred within a regional trauma system, including reasons for such transfer;

"(9) provide periodic reviews of the transfers and the auditing of such transfers determined to be inappropriate;

"(10) improve or establish injury prevention programs and conduct public education activities concerning obtaining access to emergency medical services and trauma care; and

"(11) with respect to the requirements established in paragraphs (2) through (10), provide for the coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

"(c) EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS.—Appropriate transfer policies referred to in subsection (b)(4) and section 1212(a)(3) shall include the following requirements:

"(1) MEDICAL SCREENING REQUIREMENTS.—In the case of a hospital that has a hospital emergency department, if any individual comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital shall provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (as such term is defined in section 1867(e)(1) of the Social Security Act (42 U.S.C. 1395dd(e)(1))) exists or to determine if the individual is in active labor (as such term is defined in section 1867(e)(2) of the Social Security Act (42 U.S.C. 1395dd(e)(2))).

"(2) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—

"(A) IN GENERAL.—If any individual comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor (as so defined), the hospital must provide either—

"(i) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor; or

"(ii) for transfer of the individual to another medical facility in accordance with paragraph (3).

"(B) REFUSAL TO CONSENT TO TREATMENT.—A hospital shall be considered to meet the requirement of subparagraph (A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in such clause but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

"(C) REFUSAL TO CONSENT TO TRANSFER.—A hospital shall be considered to meet the requirements of subparagraph (A) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (3) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

"(3) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZES.—

"(A) GENERAL RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (as such term is defined in section 1867(e)(4)(B) of the Social Security Act (42 U.S.C. 1395dd(e)(4)(B))) or is in active labor, the hospital may not transfer the patient.

"(B) EXCEPTION.—A patient that has not been stabilized (as such term is defined in section 1867(e)(4)(B) of the Social Security Act (42 U.S.C. 1395dd(e)(4)(B))) or is in active labor may be transferred if—

"(i)(I) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

"(II) a physician, or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based on the reasonable risks and benefits to the patient, and based on the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

"(ii) the transfer is an appropriate transfer (within the meaning of subparagraph (D)) to that facility.

"(C) REQUIREMENT.—If a patient at a hospital has an emergency medical condition that has been stabilized, the hospital may transfer the patient but only by means of an appropriate transfer.

"(D) APPROPRIATE TRANSFER.—A transfer to a medical facility is an appropriate transfer if—

"(i) the receiving facility—

"(I) has available space and qualified personnel for the treatment of the patient, and

"(II) has agreed to accept transfer of the patient and to provide appropriate medical treatment, except that a hospital may not refuse to accept a transferred patient unless such hospital does not

have the facilities or personnel available to provide proper care for such transferred patient, or the hospital has a full census at that time;

"(ii) the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment affected at the transferring hospital;

"(iii) the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

"(iv) the transfer meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the patient transferred.

"(4) CALL SCHEDULES.—In the case of a hospital that has a hospital emergency department, such hospital shall provide a call schedule that lists the appropriate medical specialists that will be immediately available for duty to provide ongoing, definitive treatment to a patient after the initial examination by the emergency physicians.

"(d) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.—

"(1) IN GENERAL.—In carrying out paragraphs (3), (4), and (5) of subsection (b), the State shall adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies. In adopting such standards the State shall—

"(A) take into account existing national standards concerning such;

"(B) consult with medical and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates and other interested parties;

"(C) conduct hearings on the proposed standards after providing adequate notice to the public concerning such hearing; and

"(D) beginning in fiscal year 1992, take into account the model plan described in subsection (e).

"(2) QUALITY OF TRAUMA CARE.—The highest quality of trauma care shall be the primary goal of State standards adopted under this subsection.

"(3) STATES WITH EXISTING STANDARDS.—In the case of a State that has adopted standards with respect to trauma care centers and systems prior to the date of enactment of this title, such State shall demonstrate in the State plan that the State standards provide for the highest possible quality of trauma care and that the State—

"(A) took into account existing national standards in adopting such standards; and

"(B) consulted with medical and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates and other interested parties.

"(4) APPROVAL BY SECRETARY.—The Secretary shall not make payments under section 1211(a) for a fiscal year if the Secretary determines that—

"(A) the State has not taken into account existing national standards in adopting standards under this subsection;

"(B) beginning in fiscal year 1992, the State has not taken into account the model plan as described in subsection (e) in adopting such standards; and

"(C) the State has not developed such standards in an open process or has not provided all interested parties an opportunity to participate.

"(e) MODEL TRAUMA CARE PLAN.—Not later than 1 year after that date of enactment of this Act, the Secretary shall develop a model plan for the designation of trauma centers and for triage, transfer and transportation policies that may be adopted for guidance by the State. Such plan shall—

"(1) take into account existing national standards;

"(2) take into account existing State plans;

"(3) be developed in consultation with medical and nursing speciality groups, hospital associations, emergency medical services State directors and associations, concerned advocated and other interested parties; and

"(4) include standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to the nearest appropriate designated trauma center, and for triage, transfer, and transportation policies as they relate to rural areas.

Standards described in paragraph (4) shall be applicable to all rural areas in the State, including both non-metropolitan areas and frontier areas that have populations of less than 6,000 per square mile.

"SEC. 1215. RERQUIREMENT OF ANNUAL REPORT BY DESIGNATED TRAUMA CENTERS.

"The Secretary may not make payments under secton 1211(a) for a fiscal year unless the State involved agrees to requrie each designated trauma center in the State to provide to the central data reporting system of the State pursuant to section 1214(b)(8) each fiscal year a report that—

"(1) specifies the number of severely-injured trauma patients cared for by such facility by injury severity grouping and nature of the injury during the fiscal year;

"(2) specifies the average length of hospital stay by such patients according to injury severity groupings during the fiscal year;

"(3) specifies the outcomes, including the disability outcome, of severely-injured trauma patients and their discharge disposition;

"(4) specifies the total amount of uncompensated trauma care expenditures incurred by such facility for such patients for such fiscal year; and

"(5) specifies the number of patients transferred in a manner not in accordance with the provisions of section 1214(c)(3)(D).

"SEC. 1216. REQUIREMENT OF PROVISION OF CERTAIN INFORMATION TO SECRETARY.

"(a) INFORMATION RECEIVED BY STATE REPORTING AND ANALYSIS SYSTEM.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that the State will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 1214(b)(8).

"(b) AVAILABILITY OF EMERGENCY MEDICAL SERVICES IN RURAL AREAS.—The Secretary may not make payments under section 1211(a) for a fiscal year unless—

"(1) the State involved identifies any rural area in the State for which—

"(A) there is no system of access to emergency medical services through the telephone number 911;

"(B) there is no basic life-support system; or

"(C) there is no advanced life-support system; and

"(2) the State submits to the Secretary a list of rural areas identified pursuant to paragraph (1) or, if there are no such areas, a statement that there are no such areas.

"SEC. 1217. RESTRICTION ON USE OF PAYMENTS.

"(a) IN GENERAL.—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

"(1) to make cash payments to intended recipients of services provided pursuant to such section;

"(2) to purchase or improve real property (other than minor remodeling of existing improvements to real property) or to purchase major medical or communication equipment, ambulances, or aircraft; or

"(3) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

"(b) EXCEPTION.—If the Secretary finds that the purpose described in section 1212 cannot otherwise be carried out, the Secretary may, with respect to an otherwise qualified State, waive the restriction established in subsection (a)(3).

"SEC. 1218. REQUIREMENT OF REPORTS BY STATES.

"(a) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees to prepare and submit to the Secretary an annual report in such form and containing such information as the Secretary determines (after consultation with the States and the Comptroller General of the United States) to be necessary for—

"(1) securing a record and a description of the purposes for which payments received by the State pursuant to such section were expended and of the recipients of such payments; and

"(2) determining whether the payments were expended in accordance with the purpose of the program involved.

"(b) AVAILABILITY TO PUBLIC OF REPORTS.—The Secretary may not make payments under section 1211(a) unless the State involved agrees that the State will make copies of the report described in subsection (a) available for public inspection.

"(c) EVALUATIONS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall, from time to time, evaluate the expenditures by States of payments under section 1211(a) in order to assure that expenditures are consistent with the provisions of the program involved.

"SEC. 1219. REQUIREMENT OF SUBMISSION OF APPLICATION CONTAINING CERTAIN AGREEMENTS AND ASSURANCES.

"The Secretary may not make payments under section 1211(a) to a State for a fiscal year unless—

"(1) the State submits to the Secretary an application for the payments containing agreements in accordance with section 1212 through section 1218;

"(2) the agreements are made through certification from the chief executive officer of the State;

"(3) with respect to such agreements, the application provides assurances of compliance satisfactory to the Secretary;

"(4) the application contains the information required to be submitted to the Secretary pursuant to sections 1214(a) and 1216(b)(2); and

"(5) the application otherwise is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

"SEC. 1220. AMOUNTS OF ALLOTMENTS.

"(a) FORMULA.—

"(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall allot to each State under section 1211(a) an amount that shall be the sum of the amounts allotted to the State under paragraphs (2) and (3).

"(2) POPULATION.—Eighty percent of the total amount made available under section 1242(b)(2) for a fiscal year shall be allotted to States under this paragraph. The allotment of a State under this paragraph shall be the amount that bears the same ratio to the amount available for allotment under this paragraph as the population of the State bears to the population of all States.

"(3) SQUARE MILEAGE.—Twenty percent of the total amount made available under section 1242(b)(2) for a fiscal year shall be allotted to States under this paragraph. The allotment of a State under this paragraph shall be the amount that bears the same ratio to the amount available for allotment under this paragraph as the square mileage of the State bears to the square mileage of all States.

"(4) MAXIMUM ALLOTMENT.—The total amount allotted to a State under this subsection shall not be greater than three times the greater of—

"(A) the amount the State would otherwise receive if a State's allotment were determined by the amount which bears the same ratio to the amount available for allotment as the population of the State bears to the population of all States; or

"(B) the minimum allotment as determined under subsection (b).

"(b) MINIMUM ALLOTMENT.—Notwithstanding subsection (a)—

"(1) if the total amount appropriated under section 1242 for any fiscal year equals or exceeds $25,000,0000, the allotment of a State under this section for such fiscal year shall not be less than the greater of—

"(A) $250,000, or

"(B) an amount equal to one-half of one percent of the total amount appropriated to carry out this part for such fiscal year; or

"(2) if the total amount appropriated under section 1242 for any fiscal year is less than $25,000,000—

"(A) the Secretary shall allot 25 percent of such amount equally among the States; and

"(B) the Secretary shall allot 75 percent of such amount according to a formula developed by the Secretary designed to target funds to States that demonstrate in their applications the greatest commitment to establishing and maintaining trauma systems and that have the greatest need to develop, implement, and maintain such systems.

"(c) DISPOSITION OF CERTAIN FUNDS APPROPRIATED FOR ALLOTMENTS.—

"(1) IN GENERAL.—Amounts described in paragraph (2) shall, in accordance with paragraph (3), be allotted by the Secretary to States receiving payments under section 1211(a) for the fiscal year (other than any State referred to in paragraph (2)(C)).

"(2) TYPE OF AMOUNTS.—The amounts referred to in paragraph (1) are any amounts made available pursuant to 1242(b)(2) that are not paid under section 1211(a) to a State as a result of—

"(A) the failure of the State to submit an application under section 1219;

"(B) the failure, in the determination of the Secretary, of the State to prepare within a reasonable period of time such application in compliance with such section; or

"(C) the State informing the Secretary that the State does not intend to expend the full amount of the allotment made for the State.

"(3) AMOUNT.—The amount of an allotment under paragraph (1) for a State for a fiscal year shall be in proportion to the amount otherwise allotted to such State for the fiscal year without regard to this subsection.

"SEC. 1221. FAILURE TO COMPLY WITH AGREEMENTS.

"(a) REPAYMENT OF PAYMENTS.—

"(1) IN GENERAL.—The Secretary may, in accordance with subsection (b), require a State to repay any payments received by the State pursuant to section 1211(a) that the Secretary determines were not expended by the State in accordance with the agreements required to be made by the State as a condition of the receipt of payments under such section.

"(2) FAILURE TO REPAY.—If a State fails to make a repayment required in paragraph (1), the Secretary may offset the amount of the repayment against any amount due to be paid to the State under section 1211(a).

"(b) OPPORTUNITY FOR A HEARING.—Before requiring repayment of payments under subsection (a)(1), the Secretary shall provide to the State an opportunity for a hearing.

"SEC. 1222. PROHIBITION AGAINST CERTAIN FALSE STATEMENTS.

"(a) IN GENERAL.—

"(1) MATERIAL FACT.—A person may not knowingly make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made by a State from amounts paid to the State under section 1211(a).

"(2) INTENT TO DEFRAUD.—A person with knowledge of the person to receive any payments from amounts paid to the State under section 1211(a) may not conceal or fail to disclose any such event with the intent of fradulently securing such amount.

"(b) CRIMINAL PENALTY FOR VIOLATION OF PROHIBITION.—Any person who violates a prohibition established in subsection (a) may for each violation be fined in accordance with title 18, United States Code, or imprisoned for not more than 5 years, or both.

"SEC. 1223. TECHNICAL ASSISTANCE AND PROVISION BY SECRETARY OF SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.

"(a) TECHNICAL ASSISTANCE.—The Secretary shall, without charge to a State receiving payments under section 1211(a), provide to the State (or to any public or nonprofit private entity designated by the State) technical assistance with respect to the planning, development, and operation of any program or service carried out pursuant to section 1212. The Secretary may provide such technical assistance directly, through contract, or through grants.

"(b) SUPPLIES AND SERVICES.—

"(1) IN GENERAL.—On the request of a State receiving an allotment under section 1211(a), the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out section 1211(b) and, for such purpose, may detail to the grantee any officer or employee of the Department of Health and Human Services.

"(2) REDUCTION IN AMOUNTS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments to the State under section 1211(a) by an amount equal to the fair market value of any supplies, equipment, or services provided by the Secretary and shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

"SEC. 1224. REPORT BY SECRETARY.

"Not later than February 1, 1993, the Secretary shall prepare and submit to the appropriate Committees of Congress a report on the activities of the States carried out pursuant to section 1211. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives and shall include—

"(1) an evaluation of the trauma system plans and standards of the State and their respective data as required by section 1216(a);

"(2) recommendations regarding the plans and standards that result in the most favorable patent outcomes; and

"(3) recommendations regarding and, if appropriate, modifications of the model State plan as required by section 1214(e).

"PART C—RURAL EMERGENCY MEDICAL SERVICES AND TRAUMA CARE

"SEC. 1231. IMPROVING RURAL EMERGENCY MEDICAL SERVICES AND TRAUMA CARE.

"(a) GRANT PROGRAM.—

"(1) IN GENERAL.—The Secretary shall make grants, on a competitive basis, to States to carry out activities to improve rural emergency medical services.

"(2) APPLICATION.—A State wishing to receive a grant under this section shall prepare and submit an application at such time, in such form, and containing such information, including the proposed activities and projects to be assisted with such grants, to the Secretary.

"(3) REDISTRIBUTION.—Grants made to States under this section shall be redistributed to the individuals, organizations, or governmental entities on whose behalf the State submitted an application under this section.

"(b) PRIORITY.—In making grants under this section, the Secretary shall give priority to—

"(1) projects aimed at filling gaps in basic and advanced life support emergency medical services in rural communities;

"(2) projects that are necessary in order for the State to carry out the activities described under section 1212; and

"(3) States and communities that serve large numbers of individuals that reside in rural communities;

"(c) ACTIVITIES AND PROJECTS.—Financial assistance may be provided with a grant received under subsection (a) by a State for—

"(1) the support of rural emergency medical services systems;

"(2) the recruitment, training, and retention of personnel to provide emergency medical services and system support, including first responders, emergency medical technicians, paramedics, and emergency medical services systems managers;

"(3) the purchase, ugrading, and maintenance of medical and communications equipment relating to emergency medical services, including equipment for the implementation 911 telephone systems;

"(4) the improvement and maintenance of transportation services for medical emergencies; and

"(5) the conduct of public education activities concerning preventing injuries of special concern to rural communities, including injuries to children resulting from farm equipment, and obtaining access to emergency medical services and trauma care.

"PART D—GENERAL PROVISIONS

"SEC. 1241. DEFINITIONS.

"As used in this title—

"(1) DESIGNATED TRAUMA CENTER.—The term 'designated trauma center' means a trauma center designated in accordance with the modifications to the State plan described in section 1214.

"(2) PLAN FOR THE PROVISION OF EMERGENCY MEDICAL SERVICES.—The term 'plan for the provision of emergency medical services' means a plan for a comprehensive, organized system to provide for the access, response, triage, field stabilization, transport, hospital stabilization, definitive care, and rehabilitation of patients of all ages with respect to emergency medical services.

"(3) STATE.—The term 'State' means each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

"(4) TRAUMA CARE COMPONENT OF THE PLAN FOR THE PROVISION OF EMERGENCY MEDICAL SERVICES.—The term 'trauma care component of the plan for the provision of emergency medical services' means a plan for a comprehensive health care system, within rural and urban areas of the State, for the prompt recognition, prehospital care, emergency medical care, acute surgical and medical care, rehabilitation, and outcome evaluation of seriously injured patients.

"(5) UNCOMPENSATED TRAUMA CARE EXPENDITURES.—The term 'uncompensated trauma care expenditures' means any amount that is expended by a health care facility to provide health care services to a trauma patient and for which such facility does not receive payment or reimbursement.

"SEC. 1242. FUNDING.

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there is authorized to be appropriated $75,000,000 for each of the fiscal years 1991 through 1993.

"(b) ALLOCATION OF FUNDS BY SECRETARY.—

"(1) PART A.—For the purpose of carrying out part A, the Secretary shall make available 5 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).

"(2) PART B.—For the purpose of making allotments under section 1211(a), the Secretary shall make available 80 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).

"(3) PART C.—For the purpose of making grants under section 1231(a), the Secretary shall make available 15 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).".

OTHER ACTS AFFECTED BY THIS LEGISLATION

UNITED STATES CODE

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TITLE 23—HIGHWAYS

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CHAPTER 4—HIGHWAY SAFETY

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§ 402. Highway safety programs

(a) Each State shall have a highway safety program approved by the Secretary, designed to reduce traffic accidents and deaths, injuries, and property damage resulting therefrom. Such programs shall be in accordance with uniform standards promulgated by the Secretary. Such uniform standards shall be expressed in terms of performance criteria. Such uniform standards shall be promulgated by the Secretary so as to improve driver performance (including, but not limited to, driver education, driver testing to determine proficiency to operate motor vehicles, driver examinations (both physical and mental) and driver licensing) and to improve pedestrian performance and bicycle safety. In addition such uniform standards shall include, but not be limited to, provisions for an effective record system of accidents (including injuries and deaths resulting therefrom), accident investigations to determine the probable causes of accidents, injuries, and deaths, vehicle registration, operation and inspection, highway design and maintenance (including lighting, markings, and surface treatment), traffic control, vehicle codes and laws surveillance of traffic for detection and correction of high or potentially high accident locations, and emergency services. Such standards as are applicable to State highway safety programs shall, to the extent determined appropriate by the Secretary, be applicable to federally administered areas where a Federal department or agency controls the highways or supervises traffic operations. The Secretary shall be authorized to amend or waive standards on a temporary basis for the purpose of evaluating new or different highway safety programs instituted on an experimental, pilot, or demonstration basis by one or more States, including, but not limited to, such programs for identifying accident causes, adopting measures to reduce accidents, and evaluating effectiveness of such measures, where the Secretary finds that the public interest would be served by such amendment or waiver.

(b)(1) The Secretary shall not approve any State highway safety program under this section which does not—

(A) provide that the Governor of the State shall be responsible for the administration of the program through a State highway safety agency which shall have adequate powers, and be suitably equipped and organized to carry out, to the satisfaction of the Secretary, such program[.],

(B) authorize political subdivisions of such State to carry out local highway safety programs within their jurisdictions as a part of the State highway safety program if such local highway safety programs are approved by the Governor and are in accordance with the uniform standards of the Secretary promulgated under this section[.],

(C) provide that at least 40 per centum of all Federal funds apportioned under this section to such State for any fiscal year will be expended by the political subdivisions of such State in carrying out local highway safety programs authorized in accordance with subparagraph (B) of this paragraph[.],

(D) provide for comprehensive driver training programs, including (1) the initiation of a State program for driver education in the school systems or for a significant expansion and improvement of such a program already in existence, to be administered by appropriate school officials under the supervision of the Governor as set forth in subparagraph (A) of this paragraph; (2) the training of qualified school instructors and their certification; (3) appropriate regulation of other driver training schools, including licensing of the schools and certification of their instructors; (4) adult driver training programs, and programs for the retraining of selected drivers; (5) adequate research, development and procurement of practice driving facilities, simulators, and other similar teaching aids for both school and other driver training use, and (6) driver education programs, including research, that will assure greater safety for bicyclists using public roads in such State.

(E) provide adequate and reasonable access for the safe and convenient movement of physically handicapped persons, including those in wheelchairs, across curbs constructed or replaced on or after July 1, 1976, at all pedestrian crosswalks through the State[.],

(F) provide for programs (which may include financial incentives and disincentives) to encourage the use of safety belts by drivers of, and passengers in, motor vehicles[.], *or*

"(G) provide procedures that ensure that State officials who are responsible for the administration, planning, and coordination of emergency medical services within the State have the opportunity to—

"(i) participate in the development of the State highway safety program as such program relates to emergency medical services;

"(ii) provide advice on the development and implementation of those provisions of the State highway safety program related to emergency medical services; and

"(iii) review, and comment on, any proposals to use funds provided to the State under this section for emergency medical services.".

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CONSOLIDATED FARM AND RURAL DEVELOPMENT ACT

(7 U.S.C. 1926)

CHAPTER 50—AGRICULTURAL CREDIT

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Subchapter I—Real Estate Loans

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§ 1926. Water and waste facility loans and grants

(a) CRITERIA; DEFINITIONS; LIMITATION ON ALLOWABLE USES OF FEDERAL FUNDS; INCLUSION OF INTEREST OR OTHER INCOME IN GROSS

INCOME ON SALE OF INSURED LOAN.—(1) The Secretary is also authorized to make or insure loans to associations, including corporations not operated for profit, Indian tribes on Federal and State reservations and other federally recognized Indian tribes, and public and quasi-public agencies to provide for the application or establishment of soil conservation practices, shifts in land use, the conservation, development use, and control of water, and the installation or improvement of drainage or wate disposal facilities, recreational developments, *emergency telephone service, communications equipment for emergency medical services,* and essential community facilities including necessary related equipment, all primarily serving farmers, ranchers, farm tenants, farm laborers, and other rural residents, and to furnish financial assistance or other aid in planning projects for such purposes. When any loan made for a purpose specified in this paragraph is sold out of the Agricultural Credit Insurance Fund as an insured loan, the interest or other income thereon paid to an insured holder shall be included in gross income for purposes of chapter 1 of title 26. With respect to loans of less than $500,000 made or insured under this paragraph that are evidenced by notes and mortgages, as distinguished from bond issues, borrowers shall not be required to appoint bond counsel to review the legal validity of the loan whenever the Secretary has available legal counsel to perform such review.

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